To the Honorable Douglas L. Parker:

U.S. Department of Labor

Office of the Assistant Secretary

Occupational Safety and Health Administration - Room: S2315

200 Constitution Avenue

Washington, D.C. 20210

Written Testimony before OSHA

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I. Interests of Petitioner

Petitioner Theo Allen[1] appreciates the opportunity to testify before OSHA[2], and I am submitting this written testimony to supplement my previous testimony and to describe my views on the questions that OSHA has presented. I am submitting this appendix on my own behalf, and not for anyone else or organization. I believe that my unique perspective should be considered, including due to my knowledge on the subjects acquired over the past two years and give a background into why I demanded a hearing.

In December of 2019, I graduated from the New York University Polytechnic Institute / Tandon School of Engineering with a Bachelors of Science in Applied Mathematics and a minor in Computer Science. The following January, I saw the interior of my home get painted and the

[1] This submission was primarily authored and edited by Theo Allen. Monetary contributions were not made in creating this response. No other party authored the submission in whole or in part, and no funds were contributed in making this submission. Parts of this submission are taken, with permission, from "The COVID-19 pandemic is not over: infections matter" submitted by the World Health Network and endorsed by Protect Our Future.

[2] Members of the People's CDC, a collective of public health practitioners, scientists, healthcare workers, educators, advocates, and people from all walks of life, who care about reducing the harmful impacts of COVID-19, have assisted in the research and preparation for this submission. In addition, No License for Disinformation, a group of individuals advocating for doctors who spread covid disinformation to lose their medical license, also assisted in the research and preparation of this submission. Members of the World Health Network contributed to this submission.

floors done. It was without adequate ventilation or containment measures, because of opposition to opening up the windows or bringing in tools to mitigate the ventilation. I stayed temporarily elsewhere, and had a temporary part time job. Then I moved back to my home where the chemicals could be smelled for weeks.

Meanwhile, COVID was raging in Italy and then came from Europe (although originally thought to have come from China) to New York.[3] In early March, a cluster appeared in New Rochelle, in Westchester County, which was nearby where I live. as restrictions began to be implemented. After March 15, my life largely shut down for weeks as covid-19 raged. Seeing people at home and workplaces, make it clear that this was a pandemic. Seeing the harms in Elmhurst Hospital, it was astonishing how the healthcare system has collapsed.

Afterwards, I went to Chicago. While I was concerned about the travel restrictions, in the middle of May, I was looking about how to protect myself. I looked at Fix the Mask, which actually did not fit me due to my face not fitting the brace. Nor could I do the brace to seal these loose fitting masks. I wanted a normal, but could not understand why wearing a mask was controversial and universal masking was not adopted. Then we have tried to resume our lives, but attempting to resume our lives while ignoring covid has occurred. I have repeatedly seen the attempt to return to normal, although declaring covid is over does not mean this is over.

The efforts have swayed me to join several groups. On August 26-27, 2020, I attended the virtual workshop on the transmission of covid. This conference established that the virus is airborne and that we need to utilize the fact to protect people. The virtual workshop was

[3] Gonzalez-Reiche, A. S., Hernandez, M. M., Sullivan, M. J., Ciferri, B., Alshammary, H., Obla, A., Fabre, S., Kleiner, G., Polanco, J., Khan, Z., Alburquerque, B., van de Guchte, A., Dutta, J., Francoeur, N., Melo, B. S., Oussenko, I., Deikus, G., Soto, J., Sridhar, S. H., … van Bakel, H. (2020, May 29). Introductions and early spread of SARS-COV-2 in the New York City area. *Science*, *369*(6501), 297–301. https://doi.org/10.1126/science.abc1917

recorded[4] and by addressing four questions, the path of the spread of airborne covid gave answers that can be used for public health purposes, including why we need layered interventions.[5] I took notes that were posted here and described the minutes, with a focus on the questioning of the panelists.[6] This experience got me involved with the covid is airborne group.

I was the person who caused the hashtag #COVIDisAirborne to go viral on the grounds that we need to know how the virus spreads in order to take the proper response. In January of 2021, I participated in a summit from the New England Complex Systems Institute and joined quickly thereafter End Coronavirus, which has morphed into the World Health Network. This has a goal of eliminating covid-19, a goal that could have occurred if we prioritize the Urgency of Equity and focused on an elimination strategy. More recently, I joined the vaccines plus coalition. At approximately the timeframe that OSHA released the guidance towards the end of March in 2022, I was finally able to join the People's CDC, a group of people focused on the need for an equitable response to the pandemic. This group additionally supports the Urgency of Equity.

Purchasing and wearing masks is comfortable, but countless people close to me have been encouraging me to unmask, viewing them as a nuisance. Describing covid as endemic, that I am at low risk, and that means that our lives should move on as if covid did not exist is common. Opposition to wearing masks and other mitigations is seen, including from a non confrontational approach. As we see the return to normal efforts prioritized and the attempt to live a pre-pandemic normal, the hospitalizations and deaths are not enough.

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[4] *Airborne Transmission of SARS CoV 2 A Virtual Workshop*. (2020, August 26). National Academies. Retrieved March 31, 2022, from https://www.nationalacademies.org/event/08-26-2020/airborne-transmission-of-sars-cov-2-a-virtual-workshop

[5] Samet, J. M., Prather, K., Benjamin, G., Lakdawala, S., Lowe, J.-M., Reingold, A., Volckens, J., & Marr, L. C. (2021, January 18). Airborne transmission of severe acute respiratory syndrome coronavirus 2 (SARS-COV-2): What we know. *Clinical Infectious Diseases*, *73*(10), 1924–1926. https://doi.org/10.1093/cid/ciab039

[6] https://t.co/IEsfyAToXn

I was made aware of the CDC publishing an emergency temporary standard in June of 2021. OSHA has said in the rulemaking that "One commenter requested that OSHA hold a public hearing on the rulemaking. See OSHA-2020-0004-1034, Attachment 1[7]. OSHA has agreed to do so." I requested the hearing for multiple reasons, including a desire for transparency, but also to go into depth as to the two key issues that I identified. Those issues were the failure to protect all workers and the failure to accept that the virus is airborne. These two issues were the topics that I want to discuss. When OSHA proposed the vaccine or test emergency temporary standard, I requested a hearing on that proposed rule, as well, and that the hearings be consolidated.[8] OSHA did not reach out to me on this topic. I made multiple filings in the docket OSH-2021-0007 to insist on this hearing, however. The hearing is required by section 6(b) of the Occupational Safety and Health Act (OSH Act) if an interested party requested the hearing and lays out objections. I laid out eleven grounds[9] for objecting to the OSHA emergency temporary standard, and requested a hearing on the two key issues that OSHA had and continues to have regarding the pandemic. Those are namely that not all workers are at grave risk from covid-19 and the denial that the virus is airborne.

The CDC was statutorily required to have published a notice to schedule this hearing in the Federal Register no later than August 20, 2021. Under section 6(b)(2) of the OSH Act[10], the Secretary "shall afford interested persons a period of thirty days after publication to submit written data or comments." Under section 6(b)(3)[11] of the OSH Act, OSHA is required within thirty days of the close of the comment period, if a hearing is requested, to schedule a hearing. I requested a hearing on June 21, 2020, the day on which the emergency temporary standard was

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[7] https://downloads.regulations.gov/OSHA-2020-0004-1034/attachment_1.pdf
[8] https://downloads.regulations.gov/OSHA-2021-0007-0613/attachment_1.pdf
[9] The other grounds were submitted in attachment 2 and a proposed solution was submitted in attachment number 3.
[10] 29 U.S.C. §655(b)(2)
[11] 29 U.S.C. §655(b)(3)

published in the Federal Register.[12] The unlawful delay by over seven months in publishing the notice in the Federal Register is illegal and has endangered the lives of countless workers and others.

While OSHA has provided for a limited reopening to discuss specific areas, this submission is intended to supplement my oral testimony. Consequently, I will discuss the two grounds that I demanded a hearing on, the failure to cover all workers and the denial of the scientific fact that the virus is airborne. These issues necessarily raise the question as to whether the public health recommendations from the CDC are the correct public health recommendations.[13] In order to do this, it is necessary to begin with the document that epitomizes the changes made in the public health response to the covid pandemic over the past eighteen months, the Great Barrington Declaration.

II. US Approach is Flawed

A. Great Barrington Declaration

The Great Barrington Declaration was published in October of 2020. It prioritized focused protection while denying that covid is dangerous to the vast majority of people. Unfortunately, this disastrous declaration has been adopted as the strategy in the United States. It never made sense and was based on, according to epidemiologist David Gorski “COVID-19 isn’t

[12] 86 FR 32376

[13] If the CDC recommendations on public health policies were the correct responses from a public health perspective, even if the reasoning behind them was unsound, OSHA would be making a mistake if it did not adopt those recommendations.

dangerous to most people, and therefore we should just stop trying to stop its spread and use 'focused protection' to keep massive numbers of the vulnerable from dying."[14]

Epidemiologist Gideon Meyerowitz-Katz, in an article titled "Focused Protection from the Great Barrington Declaration Never Made Sense",[15] describes focused protection as "the idea of the document was that, if we protected the elderly and vulnerable for 3–6 months, and let everyone else in society get infected, the pandemic would shortly be over and we could go back to life as normal." This idea has not worked out in practice. In fact, of the nineteen recommendations given by the Great Barrington Declaration identified in the Meyerowitz-Katz article, a majority of their recommendations were implemented before the declaration was released.

More recently, this was tied to the Urgency of Normal. The Urgency of Normal claims that mask mandates and virtual schooling cause harms that far outweigh the risks of covid-19 infection. However, according to pediatric and adolescent emergency psychiatrist and suicidologist Dr. Tyler Black, schools are often causing increased mental health effects. Suicides are highest on weekdays during school months, which infers that school days are often when suicides are increased.[16] In the first lockdown in the United Kingdom, a third of respondents in a study of 17,000 students reported improvements due to (in part) not going to school.[17]

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[14] Gorski, D. (2022, March 14). *Old antivax tropes never die: "COVID theater," "Urgency of Normal," and the Great Barrington Declaration*. Science-Based Medicine. Retrieved March 31, 2022, from https://sciencebasedmedicine.org/covid-theater-urgency-of-normal-gbd/

[15] Meyerowitz-Katz, G. (2022, March 2). *Focused Protection From the Great Barrington Declaration Never Made Sense*. Gideon MK; Health Nerd. Retrieved March 31, 2022, from https://gidmk.medium.com/focused-protection-from-the-great-barrington-declaration-never-made-sense-416b86ac5f06

[16] Black, T. (2020, August 24). *Opinion | In-person schooling is not a mental health panacea for children*. Toronto Star. Retrieved March 31, 2022, from https://www.thestar.com/opinion/contributors/2020/08/24/in-person-schooling-is-not-a-mental-health-panacea-for-children.html

[17] Soneson, E., Puntis, S., Chapman, N. *et al.* Happier during lockdown: a descriptive analysis of self-reported wellbeing in 17,000 UK school students during Covid-19 lockdown. *Eur Child Adolesc Psychiatry* (2022, February 17). https://doi.org/10.1007/s00787-021-01934-z

These arguments are not novel arguments. David Gorski said:

> *"[t]he doctors who make the sorts of arguments commonly used to say that children shouldn't be vaccinated against COVID-19 (e.g., that 'only' ~1,600 children under 18 have died of COVID-19 during the pandemic and therefore COVID-19 is not 'that dangerous' to children) don't realize that antivaxxers have been making the exactly the same argument about measles and varicella vaccines (among others) for decades. … Indeed, whenever I hear this argument, I like to counter it by observing that the measles used to kill around 500 children per year right before the measles vaccine was introduced (and a lot more a few decades before that, 6,000 per year in 1912) while varicella used to kill around 100 children per year. Of course, neither of these figures counts the many more cases of permanent neurological injury from both diseases."*

The Great Barrington Declaration was rejected in October of 2020 by public health organizations under the headline "Great Barrington Declaration is not grounded in science and is dangerous".[18] The recommendations of the Great Barrington Declaration would, in the words of the signers[19], "haphazardly and unnecessarily sacrifices lives. The declaration is not a strategy, it is a political statement. It ignores sound public health expertise. It preys on a frustrated populace. Instead of selling false hope that will predictably backfire, we must focus on how to manage this pandemic in a safe, responsible and equitable way."[20]

The World Health Organization (WHO) has been involved in funding scientists who deny that the virus is airborne. Nafeez Ahmed of the Byline Times reports that: "The deeper problem is that the main beneficiary of the WHO contract is linked to COVID-19 disinformation

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[18] American Public Health Association. (2020, October 14). *Public health organizations condemn herd immunity scheme for controlling spread of SARS-CoV-2*. American Public Health Association. Retrieved March 31, 2022, from https://apha.org/news-and-media/news-releases/apha-news-releases/2020/public-health-orgs-condemn-sars-covid2-plan

[19] This was signed by Trust for America's Health, American Public Health Association, Big Cities Health Coalition, American Academy of Social Work and Social Welfare, Association for Professionals in Infection Control and Epidemiology, Association of Public Health Laboratories, Association of Schools and Programs of Public Health, De Beaumont Foundation, Johns Hopkins Center for Public Security of the Johns Hopkins School of Public Health,National Association of County Behavioral Health and Developmental Disabilities Directors, National Association of County and City Health Officials, National Association for Rural Mental Health, National Network of Public Health Institutes, Prevention Institute, Public Health Institute, Resolve to Save Lives and Well Being Trust.

[20] American Public Health Association. (2020, October 14). *Public health organizations condemn herd immunity scheme for controlling spread of SARS-CoV-2*. American Public Health Association. Retrieved March 31, 2022, from https://apha.org/news-and-media/news-releases/apha-news-releases/2020/public-health-orgs-condemn-sars-covid2-plan

networks whose recommendations have been criticised by the WHO. Heneghan, who commentators accuse of promoting misinformation on masks and 'herd immunity', sits on the scientific advisory board of Collateral Global – a non-profit anti-lockdown venture – alongside Oxford University epidemiologist Professor Sunetra Gupta, Harvard University's Professor Martin Kulldorf, and Stanford University's Professor Jay Bhattacharya."[21]

Furthermore, even the WHO has condemned the declaration, with Dr. Tedros giving the following statement on October 12, 2020:

> *"For every country that's experiencing an increase there are many others that have successfully prevented or controlled widespread transmission with proven measures. Those measures continue to be our best defence against COVID-19. There has been some discussion recently about the concept of reaching so-called herd immunity by letting the virus spread.*
> *Herd immunity is a concept used for vaccination in which a population can be protected from a certain virus if a threshold of vaccination is reached. … In other words herd immunity is achieved by protecting people from a virus, not by exposing them to it. Never in the history of public health has herd immunity been used as a strategy for responding to an outbreak let alone a pandemic. It's scientifically and ethically problematic.*
> *Letting the virus circulate unchecked therefore means allowing unnecessary infections, suffering and death. Although older people and those with underlying conditions are most at risk of severe disease and death they're not the only ones at risk. People of all ages have died.*
> *Third, we're only beginning to understand the long-term health impacts among people with COVID-19. I have met with patient groups suffering with what is now being described as long COVID to understand their suffering and needs so we can advance research and rehabilitation.*
> *Allowing a dangerous virus that we don't fully understand to run free is simply unethical. It's not an option but we do have many options. There are many things that countries can do and are doing to control transmission and save lives."*[22]

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[21] Ahmed, N. (2021, April 21). *Scientist Linked to Great Barrington Declaration Embroiled in World Health Organization Conflict of Interest – Byline Times*. Byline Times. Retrieved March 31, 2022, from https://bylinetimes.com/2021/04/21/scientist-linked-to-great-barrington-declaration-embroiled-in-world-health-organization-conflict-of-interest/

[22] *COVID-19 Virtual Press conference transcript - 12 October 2020*. (2020, October 12). WHO | World Health Organization. Retrieved March 31, 2022, from https://www.who.int/publications/m/item/covid-19-virtual-press-conference-transcript---12-october-2020

The Great Barrington Declaration was opposed in the John Snow Memorandum[23]. The John Snow Memorandum was signed by scientific experts including Dr. Krutika Kuppalli, Covid-19 Health Operations at the WHO; Dr. Ali Nouri, leader of the Office of Congressional and Intergovernmental Affairs and Assistant Secretary at the Department of Energy; and Rochelle Walensky, Director of the Centers for Disease Control and Prevention. I did not sign this memorandum. The reason was that it included the following sentence, which in my view, denied the importance of airborne transmission of covid-19 as it contained the following sentence: "SARS-CoV-2 spreads through contact (via larger droplets and aerosols), and longer-range transmission via aerosols, especially in conditions where ventilation is poor."[24]

When discussing the nature of future spread of covid, the nature of its spread means that it will never be endemic and will remain an epidemic disease.[25] The evolution of covid to become more transmissible is a disaster. We need to listen to the message of the John Snow Memorandum, that CDC Director Walensky is a signatory of, and not promote disaster medicine[26]. The John Snow Memorandum specifies that:

> *"Any pandemic management strategy relying upon immunity from natural infections for COVID-19 is flawed. Uncontrolled transmission in younger people risks significant morbidity and mortality across the whole population. In addition to the human cost, this would impact the workforce as a whole and overwhelm the ability of health-care systems to provide acute and routine care. Furthermore, there is no evidence for lasting protective immunity to SARS-CoV-2 following natural infection, and the endemic transmission that would be the consequence of waning immunity would present a risk to vulnerable populations for the indefinite future. Such a strategy would not end the COVID-19 pandemic but result in recurrent epidemics, as was the case with numerous infectious*

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[23] The John Snow Memorandum was organized by the New England Complex Systems Institute, which created End Coronavirus.

[24] Alwan, N. A., Burgess, R. A., Ashworth, S., Beale, R., Bhadelia, N., Bogaert, D., Dowd, J., Eckerle, I., Goldman, L. R., Greenhalgh, T., Gurdasani, D., Hamdy, A., Hanage, W. P., Hodcroft, E. B., Hyde, Z., Kellam, P., Kelly-Irving, M., Krammer, F., Lipsitch, M., … Ziauddeen, H. (2020, October 15). Scientific consensus on the COVID-19 pandemic: We need to act now. *The Lancet*, *396*(10260). https://doi.org/10.1016/s0140-6736(20)32153-x

[25] Taylor, C. (2022, February 2). *Covid will always be an epidemic virus — not an endemic one, scientist warns*. CNBC. Retrieved March 31, 2022, from https://www.cnbc.com/2022/02/02/covid-will-never-become-an-endemic-virus-scientist-warns.html

[26] This will be described subsequently as crisis standards of care.

> *diseases before the advent of vaccination. It would also place an unacceptable burden on the economy and health-care workers, many of whom have died from COVID-19 or experienced trauma as a result of having to practise disaster medicine. Additionally, we still do not understand who might suffer from long COVID."*[27]

Unfortunately, the Great Barrington Declaration is not something that can be ignored. The arguments against issuing a rule to protect workers[28] are primarily based on the premise of the Great Barrington Declaration. Consequently, the rejection of this declaration should be emphasized.

B. Corporate Interests

Over the past two years, we have seen the focus on returning to normal spread by the special corporate interests. With the public health protections to control the spread of the virus not yet implemented to their maximum, and on March 20, 2020, Americans For Prosperity submitted in response to the shutdowns of nonessential business: "Rather than blanket shutdowns, the government should allow businesses to continue to adapt and innovate to produce the goods and services Americans need, while continuing to do everything they can to protect the public health."[29] As tweeted by Jordan Barab, former deputy Assistant Secretary for OSHA, quote retweeting me on April 8, 2021 "The problem with voluntary guidelines is that not every employer volunteers. Workers need an enforceable #OSHA standard. Not today, not even 3 weeks ago, but one year ago."[30]

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[27] Alwan, N. A., Burgess, R. A., Ashworth, S., Beale, R., Bhadelia, N., Bogaert, D., Dowd, J., Eckerle, I., Goldman, L. R., Greenhalgh, T., Gurdasani, D., Hamdy, A., Hanage, W. P., Hodcroft, E. B., Hyde, Z., Kellam, P., Kelly-Irving, M., Krammer, F., Lipsitch, M., … Ziauddeen, H. (2020, October 15). Scientific consensus on the COVID-19 pandemic: We need to act now. *The Lancet*, *396*(10260). https://doi.org/10.1016/s0140-6736(20)32153-x

[28] Other than the legal argument that OSHA does not have the jurisdiction to issue standards in such a manner as to protect all workers pursuant to *NFIB v. OSHA*. Covid-19 is an occupational disease in workplaces, both healthcare and non-healthcare, however.

[29] Americans for Prosperity. (2020, March 20). *AFP Responds to States Shutting Down All Non-Essential Businesses*. Americans for Prosperity. Retrieved March 31, 2022, from https://americansforprosperity.org/afp-responds-to-states-shutting-down-all-non-essential-businesses/

[30] Barab, J. (2021, April 8). https://twitter.com/jbarab/status/1380132528699359234?s=20&t=8EPcLClghcUo4MxHEJyoVw

The questions as to whether "Now, the fossil fuel industry is struggling amid government lockdowns aimed at preventing the spread of the coronavirus, and allowing people to move freely and return to work would help the sector by boosting energy demand."[31] Despite the surge in oil prices in 2022, big oil is not drilling and prices are being dramatically increased for fuel.[32] Nevertheless, the methods used, however, are not novel. "Several experts in defending scientific integrity told DeSmog that the Great Barrington Declaration fits a pattern of vested economic interests promoting fringe theories and contrarian science to downplay public health and safety risks in areas ranging from tobacco to chemicals to climate pollution."[33]

A study from Kansas[34] and Tennessee[35] showing counties with mask mandates had fewer covid cases. The Tennessee study showed fewer covid hospitalizations occurred for hospitals whose patient population came from counties with mask mandates. A study from Missouri showed major cities with mask mandates had fewer cases, but that study was only made public due to a Sunshine Law request.[36] Disregarding this, the American Institute for Economic Research has stated in their March 2022 update the following: "Never again should governments and schools force mask wearing. Masks always lacked research justification, had no discernible

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[31] Americans for Prosperity. (2020, March 20). *AFP Responds to States Shutting Down All Non-Essential Businesses*. Americans for Prosperity. Retrieved March 31, 2022, from https://americansforprosperity.org/afp-responds-to-states-shutting-down-all-non-essential-businesses/

[32] Ivanova, I. (2022, March 25). *U.S. producers reluctant to drill more oil, despite sky-high gas prices*. CBS News. Retrieved March 31, 2022, from https://www.cbsnews.com/news/oil-production-prices-us-companies-wont-increase-2022-dallas-fed-survey/

[33] Drugmand, D. (2020, October 26). *A Right-Wing Think Tank Is Behind the Controversial Great Barrington Declaration Calling for COVID-19 Herd Immunity*. DeSmog. Retrieved March 31, 2022, from https://www.desmog.com/2020/10/26/american-institute-economic-research-great-barrington-declaration-herd-immunity-covid-19/

[34] Van Dyke, M. (2020, November 27). *Trends in County-Level COVID-19 Incidence in Counties With ...* CDC. Retrieved April 6, 2022, from https://www.cdc.gov/mmwr/volumes/69/wr/mm6947e2.htm?s_cid=mm6947e2_w

[35] Gavulic, K., Lowary, J., & Zhou, Z. (2020, October 27). Vanderbilt COVID Report-Oct 27. Retrieved April 6, 2022, from https://www.vumc.org/health-policy/sites/default/files/public_files/Vanderbilt%20COVID19%20Report-Oct%2027.pdf

[36] This is the Missouri form of the Freedom of Information Act.

effect on viral spread, and they promoted other unhealthy behaviors." [37] This linked to "research that used randomized controlled trials (RCTs) that masks were ineffective as protection against viruses"[38] An RCT was also held for parachutes, which held that parachutes were ineffective against preventing deaths when jumping out of airplanes.[39]

Another example, the National Restaurant Association, has been described in *Mother Jones*, where the modeling of superspreader events contributing to a large majority of cases was seen.[40] To the contrary, superspreader events have been known[41] to have occurred and been caused by the spread of the virus.[42] While the National Restaurant Association cites several issues, including "Did not include mask wearing in the analysis".[43] Did indoor dining mean that people were wearing masks except when actively eating or drinking and not talking during these times? I do not believe that was being enforced. Instead, the Boston Globe gives a stronger suggestion, that the environment of a restaurant is conducive to the spread of the virus. [44] In

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[37] Sanders, J. (2022, March 27). *How Threat-Free Are Americans from COVID-19? Late March 2022 Update*. American Institute for Economic Research. Retrieved March 31, 2022, from https://www.aier.org/article/how-threat-free-are-americans-from-covid-19-late-march-2022-update/

[38] Sanders, J. (2021, August 6). *A Tale of Two Spikes: How the Tullock Spike Gives Insight Into a...* American Institute for Economic Research. Retrieved March 31, 2022, from https://www.aier.org/article/a-tale-of-two-spikes-how-the-tullock-spike-gives-insight-into-a-viral-spike-amid-forced-mask-wearing/

[39] Yeh, R. W., Valsdottir, L. R., Yeh, M. W., Shen, C., Kramer, D. B., Strom, J. B., Secemsky, E. A., Healy, J. L., Domeier, R. M., Kazi, D. S., & Nallamothu, B. K. (2018). Parachute use to prevent death and major trauma when jumping from aircraft: Randomized Controlled Trial. *BMJ*. https://doi.org/10.1136/bmj.k5094

[40] https://www.nature.com/articles/s41586-020-2923-3.epdf?sharing_token=d0_s21KoBOO_2RBPAfvRnNRgN0jAjWel9jnR3ZoTv0P4QCkIKJMffNLo7c2z6ZZT-BGx2DFzJBQwt8odUTyS1TCNvpMryEkiUGxxLeJkTyonHZobt9KltJcbVI989zhv-8S9Im6oG6kLTV5w9SWjTrJJkISUz1gDdj412cvyA9U%3D

[41] The evidence is not as strong regarding recent variants. Since the cause is likely because of the reduced contact tracing, and given, as will be subsequently described, the fact that newer variants are becoming "more fit", the role of superspreading should not be discounted.

[42] Althouse BM, Wenger EA, Miller JC, Scarpino SV, Allard A, Hébert-Dufresne L, et al. (2020) Superspreading events in the transmission dynamics of SARS-CoV-2: Opportunities for interventions and control. PLoS Biol 18(11): e3000897. https://doi.org/10.1371/journal.pbio.3000897

[43] *Like polling data, modeling data has inherent limitations when predicting outcomes*. NRA. (n.d.). Retrieved March 31, 2022, from https://web.archive.org/web/20211014151631/https://restaurant.org/news/pressroom/press-releases/like-polling-data-modeling-data-has-inherent-limit

[44] Moore, D. (2020, December 19). *New science reevaluates risks of indoor dining*. The Boston Globe. Retrieved March 31, 2022, from

addition, aerosol scientist Doctor Linsey Marr, who refuted Dr. Jay Butler's presentation at the Environmental Health Matters on droplet transmission and settled the record that covid is airborne[45], has commented that it only takes a few minutes to spread covid-19 in such a setting.[46]

A third example is the travel industry. Delta Airlines sent a letter signed by Carlos Del Rio, the President-elect of the Infectious Disease Society of America[47] which was based on "With the rapid spread of the Omicron[48] variant, the 10-day isolation for those who are fully vaccinated may significantly impact our workforce and operations."[49] While the letter mentioned using a negative test, the CDC declined subsequently to recommend this.

Subsequently, on March 22, US Travel sent a letter to Ashish Jha, the replacement for Jeffrey Zients[50] which included significant misinformation. In the following portion, except for declining hospitalizations, this is mirroring the Great Barrington Declaration.

> *"Because of the progress that's been made, you are stepping into this role at a pivotal time where declining hospitalization rates, increased immunity, widely available vaccines and cutting-edge treatments will allow endemic focused policies to replace pandemic-driven restrictions." To this end, we respectfully urge you to quickly focus on replacing pandemic-era travel advisories, requirements and restrictions with endemic-focused policies of a 'new normal' that enable travel to resume fully, freely and safely.*
> *Throughout the pandemic, we strongly supported federal policies that were necessary to combat COVID-19 and keep travel moving safely, including a vaccine requirement to restart international travel and the federal mask mandate. Unfortunately, despite declining hospitalizations and infections, increased vaccination rates and immunity, and a more robust public health infrastructure to manage the virus, the vast majority of*

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https://www.bostonglobe.com/2020/12/19/metro/superspreader-destinations-what-makes-indoor-dining-during-covid-19-so-risky/

[45] https://twitter.com/UniversalMaski2/status/1308048865866768384?s=20&t=rLQjcAIYr0eAMC15rHOHBQ

[46] Gardner, L. (2022, April 8). *Covid in D.C.: What to know about the risks of Omicron and BA.2*. Politico. Retrieved April 8, 2022, from https://www.politico.com/news/2022/04/08/dc-covid-omicron-ba2-risks-what-to-know-00023920

[47] Doctor Carlos Del Rio was President-elect at the time of the submission of this letter and remains in such a position today.

[48] "Omicron" meant during this time period BA.1.

[49] Rio, C. d., Ting, H., & Bastian, E. (2021, December 21). *Delta Letter to CDC – December 21, 2021*. Delta News Hub. Retrieved March 31, 2022, from https://news.delta.com/sites/default/files/2021-12/delta-letter-to-cdc-december-21-2021.pdf

[50] I applaud the successful work of Marked by Covid and others in getting Jeffrey Zients removed from the administration.

> *pandemic-driven federal travel policies are still in place. What's most concerning is that, while the public health benefits of these policies have greatly diminished, the economic consequences continue to grow."*[51]

The claim that the public health benefits of mitigations against uncontrolled covid have "greatly diminished" is not merely inaccurate. While the increased transmissibility of the variants mean tools are less effective, because the mode of transmission did not change, the reduction is not as great as anticipated. Furthermore, the plan recommends setting timelines, when what we need instead are data driven policies that recognize the harm faced by workers and others[52]. Simply because they recommend eliminating pre departure testing, while claiming that it would not increase the spread of covid, when elimination of such testing would increase the spread of the virus.[53] Furthermore, while repealing the indoor mask mandate on transportation (as well as other settings) would align with the CDC guidance for indoor mask wearing, that guidance is irrational from a public health perspective.

Even in the healthcare industry, we have seen that they also filed against the OSHA vaccine or test rule.[54] The National Association of Chain Drug Stores submitted a formal comment where they support an exemption for prior infection. The American Dental Association comments on how this could make it difficult to hire workers. While I agree with the shortages, the assumption that this rule would increase shortages ignores what has created the shortages since March of 2020. Assuming that mask or vaccine mandates will worsen staffing levels ignores the consequences of epidemic covid in creating burnout.

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[51] Dow, R. (2022, March 22). *1 Roger Dow President and CEO US Travel Association*. US Travel Association. Retrieved March 31, 2022, from https://www.ustravel.org/sites/default/files/2022-03/3.22-ustlettertojha-a.pdf

[52] Raifman, J., Skinner, A., & Sojourner, A. (2022, February 7). *The unequal toll of COVID-19 on workers*. Economic Policy Institute. Retrieved March 31, 2022, from https://www.epi.org/blog/the-unequal-toll-of-covid-19-on-workers/

[53] While pre departure testing does reduce the spread of covid-19, the refusal to implement the policy of testing inside the United States combined with adequate isolation and contact tracing recommendations makes these significantly less effective.

[54] Ramaswami, A. (2022, January 7). *The Corporate Campaign Against Pandemic Protections*. The Lever. Retrieved April 1, 2022, from https://www.levernews.com/the-corporate-campaign-against-pandemic-protections/

C. Political Interference

Since the early days of the administration, the political response to the pandemic has been pushing towards eliminating restrictions and returning towards a pre-2020 normal that is unachievable. The ex parte commentary[55] with the Office of Management and Budget, which I did not have, showed the interests of lobbyists arguing to stay the vaccine mandate until after the holidays. Nevertheless, over half of all state legislatures have passed laws restricting public health powers.[56] The delay of the vaccine or test emergency temporary standard to after the 2021 elections is another example of political interference.

This was recognized by the People's CDC in a publication which was made in The Guardian where the change to community levels was described, in addition to being clearly focused on not stopping transmission and shifting the burden onto those who are most at risk, include the politicized nature of the covid-19 guidelines.[57] The authors state:

> *Thirdly, the guidelines are blatantly political. The new recommendations aim to convince the public that this pandemic is over when it is not. They suggest we tolerate the nearly one million US dead, and too-quickly abandon measures that would keep that number from growing. They suggest we continue to isolate those with chronic illness and disability while the rest return to "normal" life. They suggest Long Covid isn't the rapidly growing crisis that it is, especially for those fully vaccinated, despite documented risks of ongoing and sometimes disabling symptoms. They dismiss the near-inevitable emergence of new variants. They dismiss the urgency to vaccinate the rest of the world.*[58]

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[55] If OSHA did not unlawfully delay the publication in the Federal Register of this hearing by seven months, in my view, the prohibition in section 557(d) of title 5 against ex parte communications would have applied to the employers (as well as unions, and other interested parties) no later than August 20, 2021.

[56] Weber, L., & Barry, A. M. (2021, September 15). *Over Half of States Have Rolled Back Public Health Powers in Pandemic*. Kaiser Health News. Retrieved March 31, 2022, from https://khn.org/news/article/over-half-of-states-have-rolled-back-public-health-powers-in-pandemic/

[57] Theo Allen is a member of the People's CDC, but did not sign the open letter printed in *The Guardian* due to having only recently joined the group.

[58] The People's CDC. (2022, April 3). *The CDC is beholden to corporations and lost our trust. We need to start our own | The People's CDC*. The Guardian. Retrieved April 4, 2022, from https://www.theguardian.com/commentisfree/2022/apr/03/peoples-cdc-covid-guidelines?CMP=Share_AndroidApp_Other

Unfortunately, industrial hygienists have contributed to the political interference. Notwithstanding that the Bangladesh randomized cluster trials[59] showed a one in three reduction in caseload for individuals ages 60 and over. Stephen E. Kelly has testified in a Kentucky court "Masks have 0% effectiveness"[60] Relying on the winter curve, with cases rising after mask mandates are implemented, Kelly cites Emily Oster. Unfortinentally, this analysis, similar to other works of Emily Oster, is based on a flawed individualized cost benefit analysis[61] which concludes that schools do not contribute to the spread of the virus. This includes barely not being significant, notwithstanding a 31% reduction in cases at 6 feet apart compared to 3 feet in schools.[62] Furthermore, ignoring the virus does not travel naked[63], Kelly uses an artificially small size for the aerosols.[64] In addition, looking for a 90% solution, a 2018 study on volcanic ash showed a non fit tested N95 is over 90% effective.[65]

Kelly tries to make it seem as if viruses travel somehow differently through the air compared to mold or tuberculosis, masks should only be used in accordance with 29 C.F.R

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[59] Abaluck, J., Kwong, L. H., Styczynski, A., Haque, A., Kabir, M. A., Bates-Jefferys, E., Crawford, E., Benjamin-Chung, J., Raihan, S., Rahman, S., Benhachmi, S., Bintee, N. Z., Winch, P. J., Hossain, M., Reza, H. M., Jaber, A. A., Momen, S. G., Rahman, A., Banti, F. L., … Mobarak, A. M. (2022). Impact of community masking on COVID-19: A cluster-randomized trial in Bangladesh. *Science*, *375*(6577). https://doi.org/10.1126/science.abi9069

[60] Petty, S. E. (2022, January 27). *Why Masks Do Not and Can Not Work*. Granite Grok. Retrieved April 6, 2022, from https://granitegrok.com/wp-content/uploads/2022/04/1_Petty_New_Hampshire_Legislature_Presentation_January_27_2022.pdf slide 7

[61] Cartus, A., & Feldman, J. (2022, March 22). *Motivated Reasoning: Emily Oster's COVID Narratives and the Attack on Public Education • Protean Magazine*. Protean Magazine. Retrieved April 6, 2022, from https://proteanmag.com/2022/03/22/motivated-reasoning-emily-osters-covid-narratives-and-the-attack-on-public-education/

[62] Klein, B., & Harris, D. A. (2022, March 5). Examining the robustness of 3ft versus 6FT of physical distancing in schools: A reanalysis of Van den Berg et al. (2021). *Clinical Infectious Diseases*. https://doi.org/10.1093/cid/ciac187

[63] Jimenez, J. L. (2021, May 29). https://twitter.com/jljcolorado/status/1391593087663751173?s=20&t=0U7L3RKQHWIPG1Z20acTtg

[64] Petty, S. E. (2022, January 27). *Why Masks Do Not and Can Not Work*. Granite Grok. Retrieved April 6, 2022, from https://granitegrok.com/wp-content/uploads/2022/04/1_Petty_New_Hampshire_Legislature_Presentation_January_27_2022.pdf slide 23

[65] Steinle, S., Sleeuwenhoek, A., Mueller, W., Horwell, C. J., Apsley, A., Davis, A., Cherrie, J. W., & Galea, K. S. (2018, July). The effectiveness of respiratory protection worn by communities to protect from volcanic ash inhalation. part II: Total inward leakage tests. *International Journal of Hygiene and Environmental Health*, *221*(6), 977–984. https://doi.org/10.1016/j.ijheh.2018.03.011

1910.134, mentions the sickness or death claims,[66] and discusses the supposed harms to children learning, which are minimal for the vast majority of children.[67] Instead, Stephen Kelly recommends ionizers, contrary to the recommendations of Doctor Kimberly Prather[68] and other aerosol scientists. This was presented before the New Hampshire Legislature on January 27, 2022.

Tammy Clark and Kristen Meghan Kelly testified before the North Dakota Legislature on April 1, 2021,[69] Clark said you have to do a medical fit evaluation to even determine " ifa person is even healthy enough to work in a face covering". Megham focuses on the gold standard of a randomized controlled trial, ignoring the Bangladesh randomized cluster trial, and the fact that a mask study cannot be blinded. Megham furthermore focuses on oxygenation and gaseous exchanges, even though masks do not affect these processes, even to those who have severe chronic obstructive pulmonary disease.[70] Megham makes several claims about reasons why a person can wear a mask, yet she states 73 different reasons exist for being unable to wear a mask, including PTSD[71], asthma, and stroke.

Claiming "we have millions of people in this country forced to wear a mask without an individual health risk assessment," Kristen Megham testified that if unable to wear a mask, an employer can simply not require a person to wear a mask. Actually, in such a case, the person

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[66] Slide 44

[67] Rogers, K. (2021, August 11). *Does mask wearing harm your child's development? Experts weigh in*. CNN. Retrieved April 6, 2022, from https://www.cnn.com/2021/08/11/health/masks-child-development-effects-covid-pandemic-wellness/index.html

[68] Prather, K. (2021, December 24). https://twitter.com/kprather88/status/1474400316745347074?s=20&t=0U7L3RKQHWIPG1Z20acTtg

[69] North Dakota Legislative Branch. (2021, April 1). *Senate political subdivisions*. Video. Retrieved April 6, 2022, from https://video.legis.nd.gov/en/PowerBrowser/PowerBrowserV2/20220406/-1/19879?startposition=20210401082738

[70] Samannan, R., Holt, G., Calderon-Candelario, R., Mirsaeidi, M., & Campos, M. (2021). Effect of face masks on gas exchange in healthy persons and patients with chronic obstructive pulmonary disease. *Annals of the American Thoracic Society*, *18*(3), 541–544. https://doi.org/10.1513/annalsats.202007-812rl

[71] Post traumatic stress disorder

needs to be excluded from the workplace. They claim wearing a face covering changes the respirations, and it is harder to inhale and you need to forcibly exhale[72] and created heart attacks. What these hygienists get incorrect is that if you can't wear a respirator, you can't be exposed to the toxic hazard by your employer. This sort of testimony demonstrates why disinformation needs to be stopped.

D. CDC Response

The Center for Disease Control and Prevention (CDC) has great career scientists. However, with a lack of protections to ensure the scientific integrity of the public health recommendations from the CDC career staff, there has been meddling in the process. This has undermined the ability to trust the CDC and warrants implementing guidance. Nat Malkus Nax Malkus from the American Enterprise Institute published in Fox News asks why did the CDC abruptly change:

> "*On this count, the administration failed spectacularly. CDC's timing appears to be motivated by political expediency and little else. After all, no new scientific breakthroughs or studies spurred this change. And while the new guidance does use better data—adding county COVID-19 hospitalizations and hospital bed occupancy data to the COVID-19 case rate data—that data has been available for months. The only 'pressure on the agency' that explains the timing of Friday's announcement is political pressure."*[73]

While the authors support the CDC documents, I do not agree with the suggestion the CDC has delayed the guidance. I am asking why the guidance was changed to ignore public health. Republicans in Congress also ask about the discussion between the American Federation of teachers.[74] While the CDC may claim not to share draft guidance outside the agency, the fact

[72] My experience is that is not the case wearing a disposable N95.
[73] Malkus, N. (2022, March 4). *Biden's State of the Union unmasks the politics of the CDC*. Fox News. Retrieved March 31, 2022, from https://www.foxnews.com/opinion/biden-state-of-the-union-masks-cdc-nat-malkus
[74] Chasmar, J. (2022, March 30). *Republicans expose 'uncommon' CDC, teachers' union ties on COVID school reopening guidance in report*. Fox News. Retrieved April 1, 2022, from https://www.foxnews.com/politics/republicans-uncommon-cdc-teachers-union-school-reopening-guidance

is that the CDC is subject to interference from politicians and lobbyists. This has tainted the credibility of the CDC.[75]

The WHO has defined occupational health as “an area of work in public health to promote and maintain highest degree of physical, mental and social well-being of workers in all occupations.”[76] The Supreme Court has stated "Although Congress has indisputably given OSHA the power to regulate occupational dangers, it has not given that agency the power to regulate public health more broadly."[77]

I demanded the upcoming hearing on OSHA’s determination, or more accurately, OSHA’s adoption of the CDC’s determination, that only healthcare workers are at grave risk from covid and that covid is not airborne. While the CDC is conducting a one month internal review of its process so far during the pandemic,[78] I do not believe that is enough. While Director Walensky said in a statement “Never in its 75-year history has CDC had to make decisions so quickly, based on often limited, real-time, and evolving science,”[79] the science on many of the issues before OSHA has not evolved over the past year. The fact that the CDC guidance is “at odds with evidence-based and equitable public health practice”[80] means that OSHA cannot blindly rely upon CDC guidance.

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[75] I am not trying to suggest that the recommendations from the CDC on covid being implemented is merely a scientific determination. This is a political decision, but the political decisions should be based on public health. If the CDC recommendations are based on science, the political decisions would be better informed

[76] *Occupational health*. (n.d.). WHO | World Health Organization. Retrieved April 7, 2022, from https://www.who.int/health-topics/occupational-health

[77] *NFIB v. OSHA*

[78] Sun, L. H. (2022, April 5). CDC, under fire for covid response, announces plans to revamp agency. The Washington Post. Retrieved April 7, 2022, from https://www.washingtonpost.com/health/2022/04/04/walensky-cdc-revamp-pandemic/

[79] Sun, L. H. (2022, April 5). CDC, under fire for covid response, announces plans to revamp agency. The Washington Post. Retrieved April 7, 2022, from https://www.washingtonpost.com/health/2022/04/04/walensky-cdc-revamp-pandemic/

[80] Theo Allen is a member of the People’s CDC, but did not sign the open letter printed in *The Guardian* due to having only recently joined the group.

E. Judicial Disinformation

In the briefing before the Supreme Court, various parties have espoused disinformation on covid-19 and the pandemic. This includes America's Frontline Doctors, spreading the claims that the vaccines "serve no compelling state interest at all" and that hydroxychloroquine is a safe effective alternative.[81]

The National Federation of Independent Businesses and the OSHA cost analysis are flawed in that they fail to account for the costs of transmission of covid and cause workers to leave. The evidence has shown that the failure to control covid has driven workers out of the workplace and implementing public health measures would get people to return to work. While the brief states that "OSHA acknowledged this risk, but claims that the data suggests that the number of employees who actually leave . . . is much lower. OSHA speculates that only 1-3% of total employees will quit because of the mandate. Id. But OSHA's 1-3% estimate relies on a single article that summarizes data from health care workers—in Vermont. Id. at n.42. Even if OSHA had tried to show that the study was representative, an additional 1-3% turnover above Applicants' general attrition rate—which is already higher because of the pandemic—is a significant loss."[82] Studies have shown the attrition has been under 1% of workers, which is considerably less than the number of workers who are not in the workplace due to the failure to control transmission of COVID-19.

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[81] https://www.supremecourt.gov/DocketPDF/21/21A244/207051/20211230162830733_AFLDS%20amicus%20brief%20in%20support%20of%20emergency%20applications%20re%20OSHA%20ETS%20cases.pdf page 14

[82] https://www.supremecourt.gov/DocketPDF/21/21A244/205362/20211217194535951_Application.pdf page 31

Standard Process, Inc. claimed mass resignation would occur if the vaccine mandate was upheld[83]. Center for Medical Freedom and others[84] filed an amicus citing Robert Malone and Peter McCullough, and claims that the body attacks itself after getting vaccinated.[85] IU[86] Family for Choice, Not Mandates, Inc. filed an amicus claiming that the vaccines are not public health measures, but merely medical treatments.[87] Jason Feliciano and the International Conference of Evangelical Chaplain Endorsers filed an amicus which claimed "...Masks have a negative effect, produce harm and cause further diseases. Dr. Anthony Fauci wrote the pandemic of 1918 was not mainly caused by the virus, but by bacterial infections from mask wearing."[88] American Commitment Foundation, Inc. filed an amicus claiming that Omicron [BA.1] is not a danger[89]. They were advised in the preparation of their brief by Jay Bhattacharya and Andrew Bostom, who are not credible witnesses. Bhattacharya is a lead supporter of the disastrous Great Barrington Declaration.

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[83] https://www.supremecourt.gov/DocketPDF/21/21A244/206775/20211229132956806_Motion%20for%20Leave%20to%20File%20and%20Amicus%20Brief.pdf

[84] America's Future, California Constitutional Rights Foundation, U.S. Constitutional Rights Legal Defense Fund, Eagle Forum, Eagle Forum Foundation, Downsize DC Foundation, DownsizeDC.org, Virginia Freedom Keepers, Leadership Institute, Intercessors for America, Restoring Liberty Action Committee, and Virginia Delegate David LaRock also joined this brief.

[85] https://www.supremecourt.gov/DocketPDF/21/21A244/206988/20211230151458044_NFIB%20v.%20OSHA%20amicus%20brief.pdf page 16

[86] Indiana University

[87] https://www.supremecourt.gov/DocketPDF/21/21A244/206939/20211230124421999_IU%20VAX%20Amicus%20Brief%20FINAL.pdf

[88] https://www.supremecourt.gov/DocketPDF/21/21A244/207428/20220105155856533_21A%20OSHA%20Mandate%20Amicus.pdf page 15

[89] https://www.supremecourt.gov/DocketPDF/21/21A244/207955/20220111153826854_Amicus%20Brief.pdf

F. State Briefs before Supreme Court

The Supreme Court, when it ruled against OSHA, relied on the briefs by the state governments. In their brief, the states claim "This case does not present the question whether vaccines or vaccine mandates are wise or desirable. Instead, it presents the narrow questions whether OSHA had authority to issue the Mandate, and whether it lawfully exercised whatever authority it had."[90] While the vaccine mandates as highly desirable, and should be mandated, if OSHA is only considering the healthcare workforce[91] due to the personal protective equipment (PPE) that I recommend be worn, mandating the vaccines for healthcare workers would not be, in my view, an occupational measure[92].

The stay application continues with the sentence "For the vast majority of covered employees, the COVID-19-related risk presented by work is the same risk that arises from human interaction more broadly. The virus's 'potency lies in the fact that it exists everywhere an infected person may be—home, school, or grocery store, to name a few.'"[93] However, what is not being emphasized is that the workforce, along with schools, are often indoor settings where workers get exposed. As will be subsequently described, not using a layered approach has meant that many individuals are known to be infectious and go to a workplace, where due to peer pressure or refusal to disclose the issue, they may unmask.

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[90] https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 1

[91] I concede that NFIB v. OSHA declares a vaccine mandate for the entire workforce on covid to be outside the scope of OSHA's power. This does not negate my views submitted in previous submissions that employers should be required to ensure that their entire workforce gets vaccinated against covid-19.

[92] Healthcare workers who refuse to get vaccinated, in my view, should be terminated for incompetence and lose their occupational license. I do not understand how healthcare workers can be trusted if they refuse vaccination.

[93] https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 12

The states in their brief further comment that "What is more, the States are happy to assume that viruses are a covered danger in some workplaces. For example, COVID-19 could be a workplace risk at a lab that works with SARS-CoV-2; in that setting, work itself would expose employees to a COVID-19-related danger."[94] This concession before the Supreme Court that it is a covered danger in some workplaces is welcome, although the claim that laboratories are a significant danger to covid is not grounded in evidence. On the same page, though, when the states claim "no ordinary English speaker would describe the risk of contracting an endemic illness as a danger arising from work"[95], they make two statements that I disagree with. First, the states mistakenly describe the virus as endemic, when covid is an epidemic disease.

The states continue that

> *"That principle applies with special force here, where the agency's actions are inconsistent with its warnings of grave danger. If OSHA really believed that COVID19 satisfied the 'grave danger' standard, what could possibly justify limiting the Vaccine Mandate to companies with 100 or more employees? OSHA says it chose this number because the agency 'is less confident that smaller employers' can implement the standard's requirements 'without undue disruption.' 86 Fed. Reg. at 61403. It is inconceivable that OSHA would take administrative ease into account in deciding whether small businesses must protect their employees from a risk … that was truly 'grave.'"*[96]

I agree with the states that the limiting of the vaccine mandate to only larger employers was inconceivable, and that the costs argument was a pretext. OSHA unlawfully delayed scheduling this hearing on the healthcare standards by seven months. And when they say that not getting vaccinated is a choice or a personal medical decision, This personal choice viewpoint is

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94 https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 13

95 https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 13

96 https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 17

condemned by the People's CDC. "The health and wellness of each of us is dependent on the health and wellness of our communities, and anyone we may interact with. By again shifting toward an approach that focuses on personal choice … the CDC has shifted the burden of protecting the public's health to individuals, especially the most vulnerable."[97]

The States even cite a principal author of the Great Barrington Declaration. "And it means that the Vaccine Mandate unnecessarily applies even to workers who have acquired natural immunity. Id.; Attachment A-1, Indiana's Stay Mtn, Decl. of Dr. Bhattacharya, Doc.150, ¶23 (6th Cir.)."[98] The reliance on the Great Barrington Declaration, unfortinentally, is not new. Instead of providing me with the ability to cross examine the other parties. For example, I was not able to examine the parties on the reliability of Jay Bhattcharya. He has been found an uncredible witness in Tennessee[99] where the court took three pages to discredit him and explain why the contradictions and other disinformation is untrustworthy. This could allow me to bring up the case in *Gateway Bible Baptist Church et. al v. Manitoba*[100] where the court not only rejected the views of Dr. Bhattacharya, but commented that "I will leave aside the international consensus to the contrary and the separate but very real question as to whether the specific theory arising from the Great Barrington Declaration could ever realistically be a valid and sustainable

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[97] The People's CDC. (2022, March 4). *People's CDC Report on the US CDC's Change to COVID-19 Guidelines*. Retrieved April 1, 2022, from https://docs.google.com/document/d/1_KLdamqziNs_VEQKt7jwnBKJ4-0-uiWgWql_vmRtIWM/export?format=pdf

[98] https://www.supremecourt.gov/DocketPDF/21/21A247/205640/20211218002842314_SCOTUS%20Stay%20Request%20-%20OSHA.pdf page 20-21

[99] R.K. v. Lee, 3:21-cv-00725 pg 10-13 https://casetext.com/case/rk-v-lee-1

[100] https://www.jccf.ca/wp-content/uploads/2021/10/Gateway-Bible-Baptist-Church-et-al.-v.-Manitoba-et-al.-2021-MBQB-219.pdf

public health approach."[101] And this does not include the ruling in Florida where a judge struck down[102] the mandate and discredited Dr. Bhattacharya.

In their reply brief, the states answer on who is covered by stating "a work-related danger is a danger that arises directly out of the workplace. That generally excludes risks that arise out of routine human interaction as opposed to work or the workplace—risks like COVID-19 and violent crime. And it generally excludes other risks that we face by virtue of living on Earth in the present day—risks like exposure to community-wide air pollution".[103] While I agree that routine human interactions drive the spread of the virus, the workplace is a key place where these interactions occur.

This disinformation could have been kept out had OSHA followed the statutory process[104]. If OSHA announced in the federal register it was holding a hearing on this rule by August 20, and gave notice of my objection to the scope of the rule being unduly narrow, when the administration announced the vaccine or test rule Instead of proceeding with an emergency temporary standard, OSHA could have conducted the hearing and reopened the comment period as it did on March 23, 2022. If OSHA allowed examination and cross examination of witnesses under penalties of perjury, this sort of disinformation before the Federal Appellate Courts could have been avoided.

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101 https://www.jccf.ca/wp-content/uploads/2021/10/Gateway-Bible-Baptist-Church-et-al.-v.-Manitoba-et-al.-2021-MBQB-219.pdf paragraph 307, page 131

102 Spencer, T., & Anderson, C. (2021, August 27). *Judge blocks Florida governor's order banning mask mandates*. AP News. Retrieved April 1, 2022, from https://apnews.com/article/lifestyle-health-education-florida-coronavirus-pandemic-1908088a0b5c5b02d89fd7e007822408

103 https://www.supremecourt.gov/DocketPDF/21/21A244/207138/20220103082552049_SCOTUS%20Reply%20ISO%20Stay%20Application.pdf page 4-5 (internal citations omitted)

104 If OSHA issued the draft emergency temporary standard in March of 2021 covering all workers, I would have submitted comments on how that standard ignores that the virus is airborne and would have required changes. However, I may have declined to request a hearing be conducted.

III. Grounds for a Hearing

A. Airborne Transmission

Theo Allen petitioned for a hearing on June 21, 2021 and demanded that the CDC formally accept that Covid-19 is an airborne virus. "One commenter requested that OSHA hold a public hearing on the rulemaking. See OSHA-2020-0004-1034, Attachment 1".[105] That document, written by the undersigned, is devoted to two grounds, which are not covering all workers and denial that the virus is airborne[106]. Unfortunately, this has not happened. Given the overwhelming evidence, including my submissions to OSHA, this issue is settled to such an extent that further discussion on the fact that the virus transmits through the airborne route is merely cumulative.. Instead, I will describe why it is important to use the terminology airborne.[107]

The White House put out a press release on March 23, 2022. It states in relevant terminology that states how the virus spreads, it includes the word airborne.

> *"The most common way COVID-19 is transmitted from one person to another is through tiny airborne particles of the virus hanging in indoor air for minutes or hours after an infected person has been there. While there are various strategies for avoiding breathing that air – from remote work to masking – we can and should talk more about how to make indoor environments safer by filtering or cleaning air."*[108]

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[105] https://downloads.regulations.gov/OSHA-2020-0004-1034/attachment_1.pdf
[106] Comments on airborne transmission begin on page 45 and continue throughout the rest of that document. Note that while attachments 2 and 3 in the docket number are continuations, the file was too large to submit as one document.
[107] The issue has been extensively discussed in previous submissions. See https://downloads.regulations.gov/OSHA-2020-0004-1468/attachment_1.pdf pages 58-76 for further comments.
[108] Nelson, A. (2022, March 23). *Let's Clear The Air On COVID*. The White House. Retrieved April 1, 2022, from https://www.whitehouse.gov/ostp/news-updates/2022/03/23/lets-clear-the-air-on-covid/

The CDC has started during the pandemic to educate healthcare workers on infection control, Project Firstline, continues to use the terminology "respiratory droplets". One poster from Project Firstline reads as follows:[109]

> *"The main way that SARS-CoV-2, the virus that causes the disease COVID-19, travels between people is through RESPIRATORY DROPLETS[.]Every time you breathe out of your nose or mouth, you don't breathe out just air. You are also breathing out water. The water in your breath is what makes your glasses fog up when you are wearing a mask and why you can see your breath on a cold day. That water is respiratory droplets of different sizes that travel different distances in the air. Most droplets are so tiny, you usually can't see them. When someone is infected with SARS-CoV-2, the droplets that they breathe out have virus particles in them. As a healthcare worker, you can better protect your patients, coworkers, and yourself from COVID-19 when you understand what respiratory droplets are."*

The disconnect in terminology can be summarized in this tweet by Dr. Dustin Poppendieck, a Federal Employee and air quality researcher, who tweeted on April 18, 2021 "Droplets drop #COVIDisAirborne Respiratory droplets, tiny droplets, microdroplets, inhalable droplets, raindrops. The general public does not think of any of these floating in air moving around poor fitting masks. Aerosols. Moves like cigarette smoke."[110]

One of several reasons supporting the fact that covid spreads through airborne transmission listed by aerosol experts includes that "there is limited evidence to support other dominant routes of transmission—ie, respiratory droplet or fomite."[111][112] Public health experts

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[109] Center for Disease Control and Prevention. (n.d.). *The main way that SARS-CoV-2, the virus that causes the disease COVID-19, travels between people is through respiratory droplets*. CDC. Retrieved April 1, 2022, from https://www.cdc.gov/infectioncontrol/pdf/projectfirstline/Respiratory-Droplets-508.pdf

[110] Poppendieck, D. (2021, April 18). https://twitter.com/Poppendieck/status/1383754574306025479?s=20&t=nLAPWc0xl4cSqPf4ylbciw

[111] Greenhalgh, T., Jimenez, J. L., Prather, K. A., Tufekci, Z., Fisman, D., & Schooley, R. (2021, April 15). Ten scientific reasons in support of airborne transmission of SARS-COV-2. *The Lancet*, *397*(10285), 1603–1605. https://doi.org/10.1016/s0140-6736(21)00869-2

[112] Chen, W., Zhang, N., Wei, J., Yen, H.-L., & Li, Y. (2020, June). Short-range airborne route dominates exposure of respiratory infection during close contact. *Building and Environment*, *176*, 106859. https://doi.org/10.1016/j.buildenv.2020.106859

have called on the WHO and "national governments" to "Unequivocally declare SARS-CoV-2 an airborne pathogen and stress the implications for preventing transmission."[113]

While I have significant respect for the authors of this submission, aerosol scientists Dr. Linsey Marr and Doctor Jose Luis Jimenez, describing how the failure to use the word airborne still haunts us. "The field of medicine should not have a monopoly on the word airborne. One way to reduce the chance for confusing communication in the future is to change the designation of different categories of precautions for infection prevention and control in hospitals."[114] They note that the failure is because use of that word would mean N95 respirators[115] and the use of negative pressure rooms in hospitals, and admitting the virus is airborne would mandate using those tools. Consequently, while the authors of the *Time* article argue that hospitals should use different terminology,[116] I would argue that the need to implement airborne precautions for covid patients is vital.

In terms of healthcare workers and others subjected to the dangers of sharing air with suspect or confirmed covid patients, at least one additional measures should be implemented based on the fact that the virus is airborne. OSHA should require an airborne infection isolation room (AII room) or AII unit to be used when practical for all suspect and infectious covid patients, not just when certain medical procedures are occurring. This is an important element of airborne precautions.[117]

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[113] Covid-19: An urgent call for global "vaccines-plus" action | The BMJ found at https://www.bmj.com/content/376/bmj.o1

[114] Marr, L., & Jimenez, J. L. (2022, March 29). *How Confusion Over COVID-19 Transmission Still Haunts Us*. TIME. Retrieved April 1, 2022, from https://time.com/6162065/covid-19-airborne-transmission-confusion/

[115] Alternative types of respirators exist that can be used, including but not limited to powered air purifying respirators or elastomeric respirators. OSHA recommends these sorts of reusable respirators for aerosol generating medical procedures, however.

[116] For covid patients, respiratory protection and negative pressure are essential protections for healthcare workers and other patients, however, and need to be implemented.

[117] *Precautions | Isolation Precautions | Guidelines Library | Infection Control*. (n.d.). CDC. Retrieved April 8, 2022, from https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html

B. Risk to Other Workers

I requested a hearing on two distinct grounds, which were the exclusion of other workers and the denial that the virus is airborne. OSHA did not request comment on whether non-healthcare employees should be covered. In order to justify the claim that healthcare workplaces are uniquely at risk,

While I agree that healthcare workers are at significant risk, the risks to workers and others arise in shared indoor spaces. While healthcare workers do see a greater number of individuals who have covid, the risk in the community is not small. Many other settings also have significant risk for workers, and minimization of covid should be avoided.

The question arises as to whether or not healthcare workers are the workers who are at the greatest risk of contracting covid-19. In one preprint, studying California through November 30, 2021, the study shows stark differences. "In this study, per-capita COVID-19 mortality was 2.2 times higher among emergency workers [police officers and firefighters] than among health workers during the Winter 2020–2021 surge; this ratio grew to 3.0 during the Summer 2021 surge."[118] Comparing between low and high vaccination regions, where the cutoff is defined as 50% vaccinated as of August 1, 2021, in "the Summer 2021 surge, the peak per-capita COVID-19 mortality among non-health essential workers was 251.6 in low-vaccination regions and 108.6 in high-vaccination regions, corresponding to a relative disparity of 2.3." [119]

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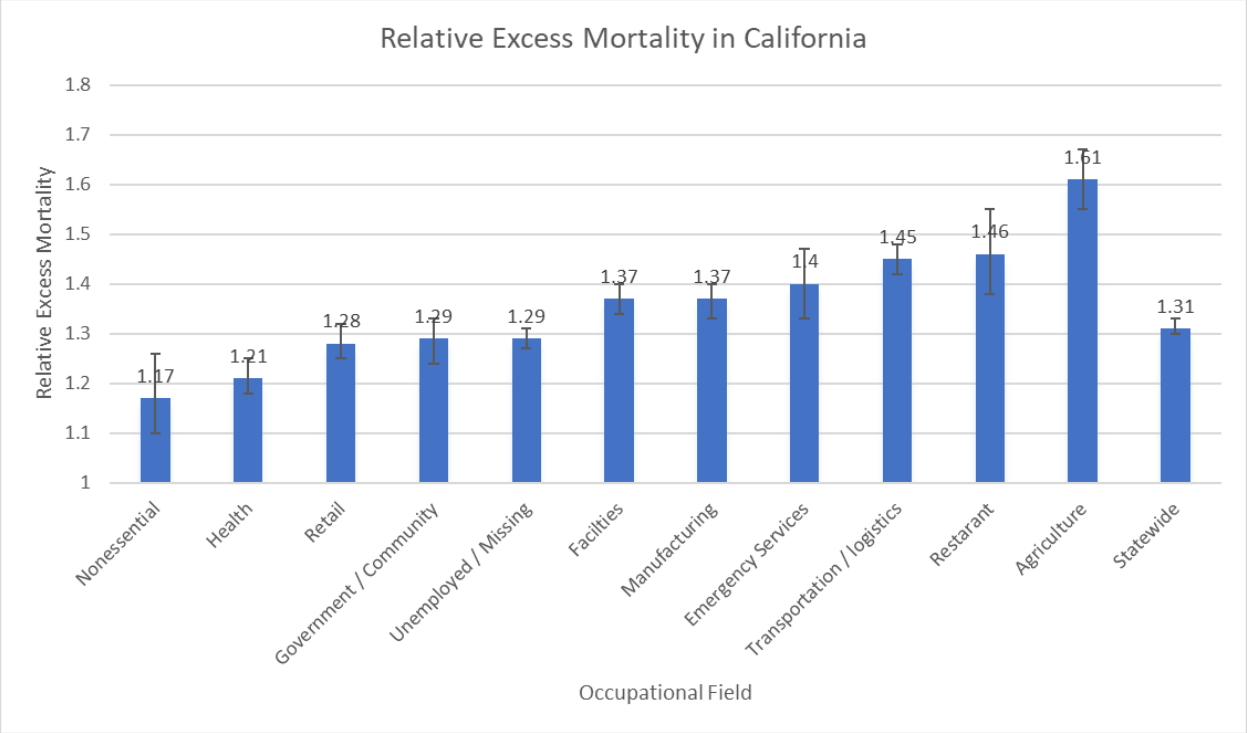
[118] Chen, Y.-H., Riley, A. R., Duchowny, K. A., Aschmann, H. E., Chen, R., Kiang, M. V., Mooney, A., Stokes, A. C., Glymour, M. M., & Bibbins-Domingo, K. (2022, February 15). Covid-19 mortality and excess mortality among working-age Californians, by Occupational Sector: March 2020 through November 2021. https://doi.org/10.1101/2022.02.14.22270958

[119] Chen, Y.-H., Riley, A. R., Duchowny, K. A., Aschmann, H. E., Chen, R., Kiang, M. V., Mooney, A., Stokes, A. C., Glymour, M. M., & Bibbins-Domingo, K. (2022, February 15). Covid-19 mortality and excess mortality among working-age Californians, by Occupational Sector: March 2020 through November 2021. https://doi.org/10.1101/2022.02.14.22270958

Instead, looking at the data from this study, comparing relative excess deaths, presents a different story. Instead of healthcare workers being among the most at risk workers in terms of mortality, the data shows that healthcare workers have the lowest rates of excess mortality among all essential workers in terms of occupational field, as described by this preprint.



When painted in this light, and considering the direct risk argument that the states made before the Supreme Court, what is clear is that essential workers should be protected against covid-19 from OSHA. They comment that without vaccine mandates,[120] we need additional steps.

> *"Community-based or employer-sponsored vaccination efforts can address structural barriers (such as limited access to transportation) and misinformation. Policies can and should address the unique challenges and risks that low-income individuals face during the pandemic, including job security, financial burdens of healthcare, and disruptions of schooling. Paid sick leave, for example, can ensure that essential workers do not have to choose between financial benefits and health risks. Finally, protections in workplace*

[120] I have previously submitted in multiple filings my support for covid vaccine mandates for employment in all sectors.

> *settings remain crucial. Given that SARS-CoV-2 [is transmitted via the airborne route][121], we urge for free provision of masks—preferably N95 masks or similarly effective masks—to essential workers and improved ventilation in workplace settings."*[122][123]

Instead of protecting workers who are at enhanced risk, OSHA is prioritizing protecting only healthcare workers.

IV. Alignment with the CDC guidance

A. Isolation Guidance [A.1]

OSHA proposes in request for comment A.1 to go towards adopting CDC guidance, including on isolation and return to work. The CDC moved towards a five day isolation guidance with masking on days six through ten. This guidance ignores that in one study of healthcare workers 58% of covid cases are infectious returning on day 6 and 26% were infectious returning on day 8 or 9. [124] In addition, positivity can still be detected via antigen tests more than 10 days after initial infection.

This unscientific recommendation should be rejected and we should have a recommendation to implement a mandatory ten day isolation period[125], and the mandatory isolation period should only be terminated after a negative test result. The recommendation from the President of the American Medical Association rejects this proposal.

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[121] The authors use "can be transmitted via aerosols". This is misleading.
[122] Chen, Y.-H., Riley, A. R., Duchowny, K. A., Aschmann, H. E., Chen, R., Kiang, M. V., Mooney, A., Stokes, A. C., Glymour, M. M., & Bibbins-Domingo, K. (2022, February 15). Covid-19 mortality and excess mortality among working-age Californians, by Occupational Sector: March 2020 through November 2021. https://doi.org/10.1101/2022.02.14.22270958
[123] Internal citations omitted
[124] Landon, E., Bartlett, A. H., Marrs, R., Guenette, C., Weber, S. G., & Mina, M. J. (2022). High rates of rapid antigen test positivity after 5 days of isolation for covid-19. https://doi.org/10.1101/2022.02.01.22269931
[125] While the World Health Network supports a 14 day isolation period with a double negative PCR test, and that would be undoubtedly better than the 10 day period at controlling the spread, my views are that the negative antigen tests are reliable enough to end isolation with a negative test. Furthermore, the PCR test picking up residual virus is a concern mentioned by the CDC.

> *"According to the CDC's own rationale for shortened isolation periods for the general public, an estimated 31 percent of people remain infectious 5 days after a positive COVID-19 test. With hundreds of thousands of new cases daily and more than a million positive reported cases on January 3, tens of thousands—potentially hundreds of thousands of people—could return to work and school infectious if they follow the CDC's new guidance on ending isolation after five days without a negative test. … A negative test should be required for ending isolation after one tests positive for COVID-19. Reemerging without knowing one's status unnecessarily risks further transmission of the virus."*[126]

In describing the isolation policy the CDC should recommend, I used the word mandatory. While assisting people can safely quarantine or isolate, including economic assistance, is important, I did not use voluntary. While the CDC may have discontinued applying travel restrictions[127] for covid cases effective on April 7, 2022,[128] and OSHA may describe it as required exclusion from work, the mandatory isolation[129] that should be recommended by the CDC is that while the government will do everything reasonably possible to minimize the harms in isolation, proper isolating is a legal duty. As a consequence, the deliberate refusal to isolate, while a public health issue, is also a public safety issue. In March of 2020, deputies surrounded the home of a person in Kentucky who refused to isolate to ensure he did not leave. [130] In my view, that was the proper response. Sadly, it appears not to have been replicated since, which suggests that public health measures can be treated as suggestions and an individual risk based approach is acceptable.

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[126] Harmon, G. E. (2022, January 5). AMA: CDC quarantine and isolation guidance is confusing, counterproductive. American Medical Association. Retrieved April 5, 2022, from https://www.ama-assn.org/press-center/press-releases/ama-cdc-quarantine-and-isolation-guidance-confusing-counterproductive

[127] I must acknowledge uncertainty about this, however.

[128] Ding, E. (2022, April 7). https://twitter.com/DrEricDing/status/1511940655194509312?s=20&t=aEzN92JiRHlZMH8D_ij1vw

[129] This also applies to quarantining. See Section IV-D for discussions on quarantining.

[130] Andrew, S. (2020, March 17). *A coronavirus patient refused to quarantine, so deputies are surrounding his house to force him to*. CNN. Retrieved April 7, 2022, from https://www.cnn.com/2020/03/17/us/kentucky-refused-quarantine-coronavirus-trnd/index.html

B. Eliminating Useless Tools

In request for comment A.2, OSHA suggests several tools where a less prescriptive approach may be appropriate. OSHA is proposing to state these as broader requirements without the level of detail specified in the previous proposals and providing a safe harbor provision based on CDC guidance.[131] I agree that various requirements should be eliminated, but not for the reason OSHA gives, which is imposing unnecessary burdens on employers.

For employers who already are subject to the healthcare emergency temporary standard[132], my proposal would actually lessen requirements that employers have. One provision of the healthcare emergency temporary standard requires in an employer's covid plan, each worker to "Minimize the risk of transmission of COVID-19 for each employee, as required by paragraphs (d) through (n) of this section".[133] Of the eleven paragraphs listed, I propose eliminating four paragraphs and amending five other paragraphs, primarily in ways that lessen restrictions on employers. Of the two remaining paragraphs, this proposal should also reduce the training required to be given to employers. Consequently, only one of the eleven paragraphs in the emergency temporary standard should not become more relaxed.[134]

I am advocating against hygiene theater, which the proposed rule includes. Consequently, in support of the fact that the virus is airborne, several measures can be safely eliminated. Focusing on what actually reduces the spread of COVID-19 means that effort would not be

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[131] Section V-A contains my comments as to why the proposal in request for comment A.2 should not be implemented. However, the recommendation as to why particular policies and procedures should not be written in prescriptive detail must be read in the context of eliminating several requirements on employers that do not reduce the spread of the virus.

[132] If OSHA correctly decides that the scope of the emergency temporary standard for healthcare was too narrow, then additional employers and additional employees would be subject to additional regulations. However, their implementation theoretically should not be as onerous as imposing the healthcare rule was in June of 2021. In practice, given the attempted return to a pre-pandemic normal throughout America, that may not be the case.

[133] 29 CFR 1910.502(c)(7)(i)

[134] I do not recommend reducing requirements in ventilation.

wasted on measures which don't stop transmission of the virus, and consequently more cases can be avoided thanks to effective and efficient adoption of mitigation resources. OSHA should instead eliminate the measures that protect against droplet and contact transmission, which are of minimal risk, and prioritize the measures that reduce airborne transmission. This should alleviate costs on employers.

The requirements for gowns, according to CDC Project Firstline, is "for this thing called contact transmission that we talked about before. This spread of germs from surfaces to people, and from people to surfaces, by touch. This spread this way is important not just for COVID-19, but for many diseases in healthcare that we're concerned about like C. difficile, MRSA, and VRE."[135] In the previous episode, Doctor Abby Carlson for Project Firstline discussed why gloves are recommended for covid, stating "But COVID-19, even though it mainly spreads by respiratory droplets, there is also some transmission or spread by touch that can happen, and we need to protect from that as well."[136] Doctor Don Milton mentions for influenza, the route of infection matters, with contact requiring hundreds of thousands of virions, compared to inhalation, which is less than ten.[137] Furthermore, if the risk for blood or bodily fluid contact exists, PPE is already required by the bloodborne pathogen standard. This requirement also leads to medical waste that the WHO calls a threat.[138] The WHO is recommending reusable PPE, which is contrary to the principles of contact precautions.

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[135] Carlson, A. (n.d.). *Episode 12: Why are Gowns Recommended for COVID-19?* https://www.cdc.gov/infectioncontrol/projectfirstline/videos/EP12-GOWNS-TranscriptAD.txt
[136] Carlson, A. (n.d.). *Episode 11: Why are Gloves Recommended for COVID-19?* https://www.cdc.gov/infectioncontrol/projectfirstline/videos/EP11-GLOVES-TranscriptAD.txt
[137] Milton, D. (2020, October 15). *Infectious Drops and Aerosols: A MIAEH Seminar by Dr. Don Milton*. YouTube. Retrieved April 6, 2022, from https://www.youtube.com/watch?v=veaaX2hJ7aw&t=1s
[138] *Global analysis of health care waste in the context of COVID-19*. (2022, February 1). WHO | World Health Organization. Retrieved April 6, 2022, from https://www.who.int/publications/i/item/9789240039612

In addition, due to the lack of contact transmission, the cleaning requirements and contact precautions are unnecessary for stopping the virus and should be eliminated[139]. Furthermore, the use of barriers should generally be eliminated as not helping reduce transmission of covid-19. As Biostatician Ryan Imgrund tweeted, "The number of businesses filled with unmasked employees, plexiglass barriers and hand sanitizer stations is indicative of how badly our public health leaders have failed us since day one."[140]

Aerosol generating medical procedures[141] do not increase the spread of covid-19 compared to talking early in infection, and the intensive care unit has lower virus levels detected compared to the home.[142] Since aerosol generating medical procedures contributing to the spread of covid-19 has been disproven, the entire concept should be removed from the OSHA regulation. The requirement to use an AII room for aerosol generating medical procedures is a requirement that should be retained. The CDC recommends "Patients with suspected or confirmed TB disease should be placed in an AII room immediately."[143] Since covid-19 is airborne, the requirement for AII rooms (or units), when feasible, should apply to all suspect or confirmed covid cases.

In addition, on fit testing, while I support the concept, the use of medical evaluations should also be discontinued when used for covid. Without the evidence that masks have caused significant harm over the preceding two years, and virtually all workers can wear respirators, these evaluations serve no useful purpose. Instead, they contribute to a pattern of burdening

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[139] The evidence in support of eye protection is weak, in the view of petitioner Theo Allen, and he would support eliminating this requirement. However, this is not a contact precaution.
[140] Imgrund, R. (2022, April 3). https://twitter.com/imgrund/status/1510652842759102472
[141] They are called "aerosol generating procedures" in the OSHA emergency temporary standard and CDC guidance.
[142] de Man, P., Ortiz, M. A., Bluyssen, P. M., de Man, S. J., Rentmeester, M.-J., van der Vliet, M., Wils, E.-J., & Ong, D. S. Y. (2022). Airborne sars-COV-2 in home and hospital environments investigated with a high-powered air sampler. *Journal of Hospital Infection*, *119*, 126–131. https://doi.org/10.1016/j.jhin.2021.10.018
[143] When to Place Patient in an AII room. (n.d.). CDC. Retrieved April 6, 2022, from https://www.cdc.gov/tb/webcourses/course/chapter7/7_infection_control_7_infection_control_program_when_to_place_patient_in_an_aii_room.html

healthcare workers whose time is precious, and promote anti-vaccine and anti-mask disinformation. If, as Kristen Megham testified, "we have millions of people in this country forced to wear a mask without an individual health risk assessment,"[144] without the evidence of people being harmed by wearing masks, the argument signals that a medical evaluation in the context of covid-19 is unnecessary.

Furthermore, a face-shield is not a substitute for a mask and that requirement should be eliminated. While a respirator blocks 99% of aerosols containing covid, and a mask, other than a respirator or a mask brace, such as Fix The Mask[145] blocks between 40% and 60% of aerosols, a face-shield blocks only 2% of aerosols.[146] They are not substitutes for a mask or respirator, and should not be required under this rule. Further details of policies that can be modified to reduce the burdens on employers without reducing protections for employees are provided in Section V-A.

C. Community Transmission Rate [A.8]

OSHA is considering in request for comment A.8 whether to adopt the use of community levels or community transmission levels to implement mitigations. Using the CDC community level metric for determining what the individual risk of getting covid or what public health actions should be taken to protect individuals from covid-19 is mistaken on a public health level.

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[144] North Dakota Legislative Branch. (2021, April 1). *Senate political subdivisions*. Video. Retrieved April 6, 2022, from https://video.legis.nd.gov/en/PowerBrowser/PowerBrowserV2/20220406/-1/19879?startposition=20210401082738

[145] *Fit Matters – Fix The Mask*. (n.d.). Fix The Mask. Retrieved April 6, 2022, from https://www.fixthemask.com/pages/fit-matters

[146] Lindsley, W. G., Blachere, F. M., Law, B. F., Beezhold, D. H., & Noti, J. D. (2021). Efficacy of face masks, neck gaiters and face shields for reducing the expulsion of simulated cough-generated aerosols. *Aerosol Science and Technology*, *55*(4), 449–457. https://doi.org/10.1080/02786826.2020.1862409

The People's CDC[147] has published in The Guardian the following statement, which describes why Community Levels should not be used:

> *"A new omicron variant, referred to as BA 2, is taking hold in the US. Anthony Fauci and others have said they don't expect a new surge in the US, but BA.2 is causing devastating surges elsewhere, and the policies and behaviors we might use to prevent a surge in the US have been widely abandoned, in part thanks to the CDC's new system for measuring and conveying Covid risk.*
> *In late February, the US Centers for Disease Control and Prevention (CDC) unveiled a new Covid-19 monitoring system based on what they call "Community Levels." By downplaying the importance of Sars-CoV-2 transmission, the new system instantly turned what was a pandemic map still red from Omicron transmission to green – creating the false impression that the pandemic is over.*
> *Released four days before the State of the Union, the new CDC measures and the narrative they created let President Biden claim victory over the virus via sleight of hand: a switch from standard reporting of community transmissions to measures of risk based largely on contentious hospital-based metrics. The previous guidelines called anything over 50 cases per 100,000 people "substantial or high." Now, they say 200 cases per 100,000 is "low" as long as hospitalizations are also low.*
> *The resulting shift from a red map to a green one reflected no real reduction in transmission risk. It was a resort to rhetoric: an effort to craft a success story that would explain away hundreds of thousands of preventable deaths and the continued threat the virus poses."*[148]

Furthermore, in the Atlantic[149] Katherine Wu asked several individuals what they think about it. Theresa Chapple-McGruder, the director of the Oak Park, Illinois Department of Public Health, was unsatisfied with these guidelines. Wu said that "'The onus of public-health measures has really shifted away from *public* and toward vulnerable individuals,' Ramnath Subbaraman, an infectious-disease physician and epidemiologist at Tufts University, told me."[150] A member of the Illinois Medical Professionals Action Collaborative Team and University of Chicago

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[147] I did not work on this publication and I did not sign the submission in The Guardian due to not being a member of The People's CDC at that time.
[148] The People's CDC. (2022, April 3). *The CDC is beholden to corporations and lost our trust. We need to start our own | The People's CDC*. The Guardian. Retrieved April 6, 2022, from https://www.theguardian.com/commentisfree/2022/apr/03/peoples-cdc-covid-guidelines?CMP=Share_AndroidApp_Other
[149] Wu, K. J. (2022, March 2). *The Biden Administration Killed America's Collective Pandemic Approach*. The Atlantic. Retrieved April 6, 2022, from https://www.theatlantic.com/health/archive/2022/03/covid-cdc-guidelines-masks/623337/
[150] Wu, K. J. (2022, March 2). *The Biden Administration Killed America's Collective Pandemic Approach*. The Atlantic. Retrieved April 6, 2022, from https://www.theatlantic.com/health/archive/2022/03/covid-cdc-guidelines-masks/623337/

infectious disease doctor, Emily Landon, according to Wu, stated "As someone who takes immunosuppressive drugs to manage rheumatoid arthritis, she appreciates the nod to the immunocompromised, but she and other experts don't see how many Americans could follow these guidelines."[151] Instead of stating that simply having a plan is enough if high risk, finding someone to check whether the numerous contraindications of Paloxoid, with pharmacists already overburdened, and the need to start treatment early, means further overwhelming the healthcare sector.

The People's CDC comments that the guidelines are not only trying to convince the public covid is over, but acceptance "that there was no way for us to avoid the nearly one million dead in the US so far. They suggest there is nothing more we can do than to let this virus spread. They suggest that those without chronic illness and disability can live a 'normal' life with COVID in the air, while those with health concerns need to be pushed inside."[152] Joshua Salomon and Alyssa Bilinski estimate these guidelines mean prevention is not warranted as long as we stay under 1000 deaths a day.[153]

The CDC, in adopting community levels, had goals in mind. They said "Neither of the community transmission indicators reflects medically significant disease or healthcare strain." even though cases lead to long covid, hospitalizations, and deaths.[154] Cases lead to hospitalization and deaths, and high caseloads lead to healthcare strain. While community levels

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[151] Wu, K. J. (2022, March 2). *The Biden Administration Killed America's Collective Pandemic Approach*. The Atlantic. Retrieved April 6, 2022, from https://www.theatlantic.com/health/archive/2022/03/covid-cdc-guidelines-masks/623337/

[152] The People's CDC. (2022, March 4). *People's CDC Report on the US CDC's Change to COVID-19 Guidelines*. Retrieved April 1, 2022, from https://docs.google.com/document/d/1_KLdamqziNs_VEQKt7jwnBKJ4-0-uiWgWql_vmRtIWM/export?format=pdf

[153] Salomon, J. (2022, March 1). https://twitter.com/SalomonJA/status/1498795776457076736?s=20&t=u1-eM5jKcYmWQB-Muxy3Pg

[154] *Indicators for Monitoring COVID-19 Community Levels and COVID-19 and Implementing COVID-19 Prevention Strategies*. (2022, February 25). CDC. Retrieved April 6, 2022, from https://www.cdc.gov/coronavirus/2019-ncov/downloads/science/Scientific-Rationale-summary-COVID-19-Community-Levels.pdf

are more correlated with healthcare systems being overwhelmed and worsened standard of care. Furthermore, excess mortality increases as ICU capacity is exceeded.[155]

However, hospitalizations are a lagging indicator, which means that they should generally not be used for public health purposes. Since cases lead to hospitalizations, public health needs to focus on reducing transmission. Nevertheless, since community levels predict crisis standards of care, they have a use. With the burden of covid at medium or high community levels on hospitals, and the elevated risks of getting infected in hospitals, OSHA can, and should, require all workers in hospitals to wear respiratory protection. Furthermore, at high community levels, it is likely necessary to consider deploying military healthcare workers and the national guard to help avoid crisis standards of care. Community transmission[156]

The use of the CDC's community level metric should be limited to determining when to deploy the military to help overwhelmed hospitals and when the risk in hospitals is so high that universal respiratory protection is needed in those settings. If this is the extent of the public health response to covid-19 recommended, we are giving up on covid, and allowing epidemic covid to run rampant. The CDC community level metric should not be used for public health purposes, such as when to recommend masks outside of the community, due to being a lagging indicator. In community settings, the CDC community transmission metric should be utilized.

The CDC also suggested using community vaccination rates for some purposes in request for comment A.5. While the metric could be used theoretically, whether someone is vaccinated is not the best measure of determining what the risk is to an individual of getting covid. Without data to suggest that the waves, such as the BA.2 wave the United States likely is in, are being

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[155] French G, Hulse M, Nguyen D, et al. Impact of Hospital Strain on Excess Deaths During the COVID-19 Pandemic — United States, July 2020–July 2021. MMWR Morb Mortal Wkly Rep 2021;70:1613–1616. DOI: http://dx.doi.org/10.15585/mmwr.mm7046a5

[156] An acceptable replacement to this tool can appropriately also be utilized, such as a metric incorporating wastewater surveillance.

stopped by immunity from vaccinations or immunity from a prior infection, which is incredibly dangerous, this approach can't predict when it is more likely that someone will be infected and die, be hospitalized, or get long covid from that infection. Using community transmission rates is a more reliable measure of this risk.

The use of metrics based on community transmission[157] does not apply when you are dealing with someone who is suspected or confirmed to have covid-19.[158] As will be subsequently discussed, a requirement for a respirator, such as a reusable elastomeric respirator, powered air purifying respirator, or N-95 needs to be mandated in such setting, irrelevant of vaccination status or the spread of covid in the community, regardless as to how it is measured[159]. OSHA is also asking for guidance on compliance and enforcement in request for comment A.8. When proper guidance is implemented, we will see stronger compliance and will not experience the bullying that occurs when, for example, masks are optional.[160]

D. Contact Tracing

OSHA is asking whether exposure notifications are appropriate to be given to vaccinated workers in request for comment A.5.3. The refusal to identify a proper contact based on shared air, and using the six (or three) feet for fifteen minutes over twenty-four hours is a relic of assuming that droplet transmission, as opposed to airborne transmission, is how covid-19 spreads. Doctor Jay Varma, who was the covid advisor to former New York City Mayor Bill

[157] Community levels should only be utilized in hospitals to mandate respirators and deploying the military to hospitals.
[158] See Section V-E as to why a respirator in such cases should be mandatory.
[159] In such cases, the community levels and community transmission metrics are irrelevant.
[160] See Section V-A for more information as to why mandatory requirements are needed.

DeBlasio, views covid as more infectious than measles.[161] We should be using the measles standard for contact tracing, which utilizes shared air.

In advocating against universal contact tracing of covid cases,[162] public health agencies[163] said that due to large numbers of asymptomatic and less severe cases, cases not being reported to public health agencies due to not being tested and at home tests being unreported, symptom onset being when cases are most severe, and the shorter incubation period[164] of covid. While some of these issues mean that contact tracing will be less effective, the solution is to increase resources. The CDC also gives high levels of immunity from vaccination and antibodies, "Availability of safe and effective vaccines and other proven tools to prevent transmission and mitigate illness", decreased participation in contact tracing, and high caserates.[165] Instead, the CDC recommends that contact tracing be prioritized to congregate living facilities, those not up to date on vaccination, and those who are at more severe risk, and implement public health campaigns to encourage practices to reduce covid. For those at risk, the CDC recommends connections for antivirals and other treatments be made.[166]

David Gorski described the Great Barrington Declaration as stating "COVID-19 isn't dangerous to most people, and therefore we should just stop trying to stop its spread and use 'focused protection' to keep massive numbers of the vulnerable from dying."[167] The question

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[161] Varma, J. (2022, January 8). https://twitter.com/DrJayVarma/status/1479833575075811332?s=20&t=0U7L3RKQHWIPG1Z20acTtg

[162] January 24, 2022 "Public Health Agencies transitioning ... (n.d.). Retrieved April 6, 2022, from http://preparedness.cste.org/wp-content/uploads/2022/01/CICT_Partner_Statement_01_24_2022.pdf

[163] The Association of Public Health Laboratories, Association of State and Territorial Health Officials, Big Cities Health Coalition, Council of State and Territorial Epidemiologists, and National Association of County and City Health Officials published this statement.

[164]They use omicron.

[165] Prioritizing Case Investigation and Contact Tracing for COVID-19. (2022, February 28). CDC. Retrieved April 6, 2022, from https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html

[166] Prioritizing Case Investigation and Contact Tracing for COVID-19. (2022, February 28). CDC. Retrieved April 6, 2022, from https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html

[167] Gorski, D. (2022, March 14). *Old antivax tropes never die: "COVID theater," "Urgency of Normal," and the Great Barrington Declaration*. Science-Based Medicine. Retrieved March 31, 2022, from https://sciencebasedmedicine.org/covid-theater-urgency-of-normal-gbd/

naturally rises, which is how can we distinguish the policy of not universally tracing covid cases from the Great Barrington Declaration that these organizations condemned in October of 2020? The American Public Health Association said that the Great Barrington Declaration "suggests allowing the virus to spread unchecked among young people to create herd immunity in the entire population. This notion is dangerous because it puts the entire population, particularly the most vulnerable, at risk."[168]

The Great Barrington Declaration website includes a list of frequently asked question. One question that the Great Barrington Declaration website asks is "Have contact tracing, testing and isolation been successful against infectious diseases?"[169] The response to this question, signaling apathy towards the process, is "Contact tracing is of critical importance for many infectious diseases. They do not work for widely spread diseases such as annual influenza, pre-vaccine measles, COVID-19, or, by definition, against any pandemic."[170] While the Great Barrington Declaration has claimed that "The focused protection strategy proposed by the Great Barrington declaration is indeed the standard way that societies have dealt with prior epidemics"[171], contact tracing was critical in stopping the 2014-2016 Ebola epidemic in West Africa.[172]

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[168] American Public Health Association. (2020, October 14). *Public health organizations condemn herd immunity scheme for controlling spread of SARS-CoV-2*. American Public Health Association. Retrieved March 31, 2022, from https://apha.org/news-and-media/news-releases/apha-news-releases/2020/public-health-orgs-condemn-sars-covid2-plan

[169] Great Barrington Declaration. (n.d.). *FREQUENTLY ASKED QUESTIONS*. Great Barrington Declaration. Retrieved April 7, 2022, from https://gbdeclaration.org/frequently-asked-questions/

[170] Great Barrington Declaration. (n.d.). *FREQUENTLY ASKED QUESTIONS*. Great Barrington Declaration. Retrieved April 7, 2022, from https://gbdeclaration.org/frequently-asked-questions/

[171] Great Barrington Declaration. (n.d.). *FREQUENTLY ASKED QUESTIONS*. Great Barrington Declaration. Retrieved April 7, 2022, from https://gbdeclaration.org/frequently-asked-questions/

[172] Bar-Yam, Y. (2016, July 11). *How Community Response Stopped Ebola — New England Complex Systems Institute*. New England Complex Systems Institute. Retrieved April 7, 2022, from https://necsi.edu/how-community-response-stopped-ebola

The fact that rejecting universal contact tracing implements the disastrous Great Barrington Declaration should signal that it is not a sound public health policy. Exposure notifications, consequently, should be treated as contact tracing. Furthermore, as demonstrated in a study at Brigham & Women's Hospital,[173] determining who is exposed allows measures that reduce onward transmission to be taken in healthcare settings. In light of the fact that six feet and fifteen minutes are inadequate tools to determine who is a close contact,[174] emphasis should be placed on ensuring that employees know their risk by requiring that times and locations where individuals who are infectious regarding covid may be found.

This raises the question as to what is the use for a covid test. I can think of three primary uses for a covid test, which are for medical treatment, prevention, and for benefits, such as death benefits or benefits for long covid. A test could be helpful for long covid in order to get social security benefits, insurance reimbursement, access to overwhelmed rehabilitation clinics, or similar uses. A test can also mean covid being listed on the death certificate, which makes someone eligible for up to nine thousand dollars in funeral assistance.[175]

Using a covid test for medical purposes means that it would help get someone a treatment, such as a Palexoid prescription. The test to treat model is what President Biden promised in the State of the Union,[176] but this does not mean it is viable. The access to early

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[173] Klompas, M., Baker, M. A., Rhee, C., Tucker, R., Fiumara, K., Griesbach, D., Bennett-Rizzo, C., Salmasian, H., Wang, R., Wheeler, N., Gallagher, G. R., Lang, A. S., Fink, T., Baez, S., Smole, S., Madoff, L., Goralnick, E., Resnick, A., Pearson, M., … Morris, C. A. (2021). A sars-COV-2 cluster in an acute care hospital. *Annals of Internal Medicine*. https://doi.org/10.7326/m20-7567

[174] Klompas, M., Baker, M. A., Rhee, C., Tucker, R., Fiumara, K., Griesbach, D., Bennett-Rizzo, C., Salmasian, H., Wang, R., Wheeler, N., Gallagher, G. R., Lang, A. S., Fink, T., Baez, S., Smole, S., Madoff, L., Goralnick, E., Resnick, A., Pearson, M., … Morris, C. A. (2021). A sars-COV-2 cluster in an acute care hospital. *Annals of Internal Medicine*. https://doi.org/10.7326/m20-7567

[175] *COVID-19 Funeral Assistance*. (2022, February 7). FEMA. Retrieved April 7, 2022, from https://www.fema.gov/disaster/coronavirus/economic/funeral-assistance

[176] Fact Sheet: Biden Administration Launches Nationwide Test-to-Treat Initiative Ensuring Rapid 'On the Spot' Access to Lifesaving COVID Treatments. (2022, March 8). HHS.gov. Retrieved April 7, 2022, from https://www.hhs.gov/about/news/2022/03/08/fact-sheet-biden-administration-launches-nationwide-test-treat-initiative-ensuring-rapid-on-spot-access-lifesaving-covid-treatments.html

treatment is not equitable already[177], and this program does not promote equity. While federally qualified health centers promote equity, chain pharmacies do not.[178] This affects low income essential healthcare workers, among others. Furthermore, this needs to consider pharmacies are already overburdened.[179]

While testing is used for prevention, it needs to be remembered that a test by itself does not prevent covid. Rather, the actions taken following knowledge of the positive test are what prevents further spread of the virus. Simply monitoring for symptoms does not prevent onward spread of the virus, but isolation and quarantine does. The CDC relies on prior infection within the last 90 days or being up to date on vaccination[180] to exempt someone from quarantine, which relies, sadly, on a flawed understanding of the response to covid from the immune system[181][182]. Furthermore, the reduced isolation guidance means that individuals exposed after five days of isolation would not be a close contact[183], despite the significant risk of being exposed when someone does not test out of isolation.[184]

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[177] Wiltz, J. L., Feehan, A. K., Molinari, N. A. M., Ladva, C. N., Truman, B. I., Hall, J., Block, J. P., Rasmussen, S. A., Denson, J. L., Trick, W. E., Weiner, M. G., Koumans, E., Gundlapalli, A., Carton, T. W., & Boehmer, T. K. (2022). Racial and ethnic disparities in receipt of medications for treatment of covid-19 — United States, March 2020–August 2021. *MMWR. Morbidity and Mortality Weekly Report*, *71*(3), 96–102. https://doi.org/10.15585/mmwr.mm7103e1

[178] Cole, M. B., Raifman, J. R., Assoumou, S. A., & Kim, J.-H. (2022). Assessment of administration and receipt of covid-19 vaccines by race and ethnicity in US federally qualified health centers. *JAMA Network Open*, *5*(1). https://doi.org/10.1001/jamanetworkopen.2021.42698

[179] See Section VI for more information on burnout.

[180] The vaccines are remarkable miracles, but are best at protecting against severe cases.

[181] See Section IV-E for more information on why the vaccines are not enough.

[182] Townsend, L., Dyer, A. H., Naughton, A., Kiersey, R., Holden, D., Gardiner, M., Dowds, J., O'Brien, K., Bannan, C., Nadarajan, P., Dunne, J., Martin-Loeches, I., Fallon, P. G., Bergin, C., O'Farrelly, C., Cheallaigh, C. N., Bourke, N. M., & Conlon, N. (2021). Longitudinal analysis of COVID-19 patients shows age-associated T cell changes independent of ongoing ill-health. *Frontiers in Immunology*, *12*. https://doi.org/10.3389/fimmu.2021.676932

[183] See Section IV-A for why the isolation guidance is too short.

[184] Landon, E., Bartlett, A. H., Marrs, R., Guenette, C., Weber, S. G., & Mina, M. J. (2022). High rates of rapid antigen test positivity after 5 days of isolation for covid-19. https://doi.org/10.1101/2022.02.01.22269931

E. Vaccination Status [A.5.1] [B.9] [C.5]

In request for comment B.9, OSHA asks about the "appropriate periodicity of additional vaccine doses".[185] In request for comment A.5.1, OSHA asks about aligning OSHA in request for comment A.5 discusses vaccination. OSHA suggests using additional doses and adjusting for staying up to date in part A.5.1. I support OSHA adopting a definition of staying up to date, by means of being vaccinated as recommended by the Advisory Committee on Immunization Practices, even though I loathe the delay in authorizing a vaccine for children under age five. The concept that a one or two dose regimen means someone is fully vaccinated should be abandoned.

The virus attacks T cells[186], including through superantigens.[187] The danger is severe to the extent that Doctor Anthony Leonardi and Adam Hamdy declares "Urgent research is needed to better understand the long-term risks being taken by governments whose policies enable widespread transmission of a potential superantigenic pathogen, and to more clearly define the vaccination and public health policies needed to protect against the consequences of repeat exposure to the pathogen."[188] This is suggesting a change is occurring towards annual vaccination doses[189], just as ACIP recommends for influenza in individuals who are at least six months old.[190] While the Vaccines and Related Biological Products Advisory Committee struggles with trying to make covid an annual vaccination, and worries about burnout of people

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[185] "Booster" doses are vaccine doses.
[186] Townsend, L., Dyer, A. H., Naughton, A., Kiersey, R., Holden, D., Gardiner, M., Dowds, J., O'Brien, K., Bannan, C., Nadarajan, P., Dunne, J., Martin-Loeches, I., Fallon, P. G., Bergin, C., O'Farrelly, C., Cheallaigh, C. N., Bourke, N. M., & Conlon, N. (2021). Longitudinal analysis of COVID-19 patients shows age-associated T cell changes independent of ongoing ill-health. *Frontiers in Immunology*, *12*. https://doi.org/10.3389/fimmu.2021.676932
[187] Hamdy, A., & Leonardi, A. (2022). Superantigens and SARS-COV-2. Pathogens, 11(4), 390. https://doi.org/10.3390/pathogens11040390
[188] Hamdy, A., & Leonardi, A. (2022). Superantigens and SARS-COV-2. Pathogens, 11(4), 390. https://doi.org/10.3390/pathogens11040390
[189] The "booster doses" should not be described as such, but as staying up to date.
[190] Summary of Recommendations. (2021, December 10). CDC. Retrieved April 7, 2022, from https://www.cdc.gov/flu/professionals/acip/summary/summary-recommendations.htm

getting vaccinated,[191] a significant probability exists that we may need vaccines every four or six months to stay up to date. Due to the increased transmissibility of covid, simply adopting the model for influenza suggests treating covid like influenza. I will recommend using the up to date terminology from the CDC and the Advisory Committee on Immunization Practices (ACIP). However, the danger from getting covid is not adequately reduced by getting vaccinated. Given the durability of the vaccines and the doses[192] in providing protection against the virus.

F. Precautions if Vaccinated [A.5.3]

OSHA asks in request for comment A.5.3 whether precautions should be reduced or eliminated based on vaccination status. This approach asks about the individual level, the percentage of staff vaccinated, and community vaccination rates. While I oppose each of these proposals, at first, it would seem that a different analysis is required for each step. In reality, though, the workplace level builds off the individual level, and the community level builds off the workplace level.

I have previously submitted, and continue to insist[193] that it should be a requirement of employment to get vaccinated, against covid. Sadly, this policy has not been implemented by OSHA to the degradation of occupational and public health. Nevertheless, changing guidance based on individual vaccination status[194] is not warranted. Data from Israel shows not only that a fourth dose has benefits in protection over a third dose, but that the protection from vaccination

[191] Howard, J. (2022, April 6). *FDA vaccine advisers say a plan for updating Covid-19 shots is needed*. CNN. Retrieved April 7, 2022, from https://www.cnn.com/2022/04/06/health/fda-vrbpac-covid-boosters-meeting/index.html
[192] The "booster doses" should not be described as such, but as staying up to date.
[193] See Section V-C for further discussion on this issue.
[194] Individual vaccination status is discussed in Section IV-E.

wanes with time, particularly against transmission.[195] In this context, short term protections, likely from antibodies, appears as the key protection.

If the vaccines or prior infection provides only temporary "protection" from infection, then any easing of protections from vaccination should only be temporary. Nevertheless, turning on these protections will not be easy. Relying on temporary protections leads to the CDC getting into a cycle of frequently reducing guidelines, as described by Protean on Emily Oster's work, demonstrating why this approach is unworkable.

> *"Throughout the pandemic, Oster's advocacy has helped make the 'data-driven' case for peeling away successive layers of COVID mitigations: first ending remote instruction in favor of hybrid learning, then ending hybrid learning in favor of a full return to in-person instruction, then eliminating quarantine for those exposed to the virus. The direction of her vision for schooling during the pandemic ultimately involves abandoning universal public health measures altogether, turning masking and vaccination into individual, personal choices that can be decided through cost-benefit calculations.*

In viewing why we cannot trust this individual risk assessment, the collaboration between Emily Oster and Jay Bhattcharya, coauthor of the disastrous Great Barrington Declaration, must be emphasized. On January 9, 2021, Teacher 4 Open Schools held an event where the experts Bhattacharya and Oster said that schools are safe and should be open.[196] We should not rely on this individual approach which is based on the Great Barrington Declaration.

On a workplace level, one question is what are workers being protected from. If OSHA believes that, based on legal or political grounds, the only locations that warrant protection from OSHA are healthcare workers around patients, an argument can be made to exclude areas where patients are not found. If OSHA believes that, based on legal or political grounds, the only workers who warrant protections from covid are unvaccinated, then vaccinated workers can be

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[195] Bar-On, Y. M., Goldberg, Y., Mandel, M., Bodenheimer, O., Amir, O., Freedman, L., Alroy-Preis, S., Ash, N., Huppert, A., & Milo, R. (2022). Protection by a fourth dose of BNT162B2 against Omicron in Israel. New England Journal of Medicine. https://doi.org/10.1056/nejmoa2201570

[196] Teachers 4 Safe Schools. (2021, January 9). *Are Schools Safe? Teachers & Experts on school re-opening Jay Bhattacharya, MD PhD Emily Oster PhD*. YouTube. Retrieved April 7, 2022, from https://www.youtube.com/watch?v=SQ46RKg2604

exempted. OSHA should not claim, however, that these sorts of determinations are warranted based on science, occupational health, or public health. Two grounds for using this approach exists, which are voluntary compliance and herd immunity from vaccination. Neither reason is justifiable.

Voluntary compliance is the theory that employers would voluntarily impose covid measures because the harms of covid are unacceptable. If voluntary compliance was adequate, then OSHA would have not published in the Federal Register for the vaccine or test emergency temporary standard "OSHA has found that neither reliance on voluntary action by employers nor OSHA non-mandatory guidance is an adequate substitute for specific, mandatory workplace standards at the federal level."[197] Furthermore, expecting voluntary reintroduction of measures ignores the trend of primarily loosening restrictions seen over the past two years.

Finally, in terms of considering vaccination rates in the community, this argument actually is an argument for herd immunity based on vaccination. While the Great Barrington Declaration advocates for infection driven immunity, the argument of herd immunity for covid is an argument in favor of the disastrous Great Barrington Declaration, an antithesis to public health. Carl Heneghan's, a person who sits on the board of Collateral Global, a charity focused on studying the impact of covid by not fully implementing the Great Barrington Declaration, and who submitted a paper that failed peer review denying the scientific fact that covid is airborne, made these arguments.[198] If this strategy is going to be implemented, OSHA and the CDC should focus on increasing test reporting, including at home tests, and use community transmission rates.[199]

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[197] 86 F.R. 61445

[198] Ahmed, N. (2021, April 21). *Scientist Linked to Great Barrington Declaration Embroiled in World Health Organization Conflict of Interest – Byline Times*. Byline Times. Retrieved March 31, 2022, from https://bylinetimes.com/2021/04/21/scientist-linked-to-great-barrington-declaration-embroiled-in-world-health-organization-conflict-of-interest/

[199] See Section IV-C for discussion on why community transmission rates should be used.

OSHA also asks about exposure notifications and elimination of masks, barriers, and physical distancing in request for comment A.5.3. My recommendations are not to use vaccination status in determining whether to modify either of these measures. My comments about eliminating unnecessary tools in Section IV-B specifically recommend elimination of physical barrier requirements on the grounds they do not reduce transmission of covid-19. My comments in Section V-E discuss why, in limiting protections against covid, exposure notifications should not be limited. On masks and distancing, the comments in this section should be applied to those policies.

V. Other Implementation Measures

A. Flexibility for Employers [A.2]

OSHA proposes flexibility for the employers in request for comment A.2. We have seen that the failure to implement mandates and stringent standards leads to a minimalistic approach being taken, which benefits the employers who do not take the effort to protect workers. OSHA should not include an unprecedented and unlawful safe harbor provision. OSHA, instead, should comply with section 6 of the OSH Act, which requires the standard that most adequately protects workers from the harm of covid-19. The prescriptive standards are largely appropriate, but various standards can be eliminated safely.

Under this standard, in addition to the elimination of unnecessary tools,[200] additional measures can be taken. These include "Implement other applicable patient management strategies".[201] While healthcare workers should be required to appropriately screen and triage

[200] See Section IV-B for further details on the various tools that should be eliminated.
[201] 29 C.F.R 1910.502(d)(3)

individuals based on covid status, and be trained on how to do this, employers should be able to rely on the trained medical judgment of healthcare professionals. While the regulation requires limiting entrances to healthcare settings as well as monitoring them, I would recommend that screening be required as early as practical considering the need to triage covid patient expeditiously to stop nosocomial transmission. I am not asking for an absolute triage requirement because in some circumstances, that will not be appropriate. While it might seem appropriate to implement this as a requirement in an OSHA regulation, I can see a minimum of two cases where an inflexible mandate would not serve the public health goals of protection from covid. It might take less time to get a prescription in a pharmacy than it takes to screen someone for covid. A person entering an emergency room who requires immediate care may be delayed by a requirement to conduct triage. In inpatient settings, such as an emergency department, screening and triaging likely means administering two covid tests, a rapid test for isolation purposes, and a PCR test for diagnostic purposes.

The requirement to follow standard and isolation precautions,[202] in addition to being duplicative of the OSHA guidelines, also includes various elements that constitute hygiene theater. This means that it imposes unnecessary requirements on employers that should be eliminated. I have recommended the elimination of additional surface cleaning requirements for covid.[203] On PPE, I have already recommended eliminating contact precautions,.This would provide a reduction in requirements on employers without diluting protections against airborne transmission of covid-19. Other measures are remote such that no further precautions are needed against them. This also would include the physical barriers in non patient care areas[204]

[202] 29 C.F.R. 1910.502(e)
[203] 29 C.F.R. 1910.502(j)
[204] 29 C.F.R. 1910.502(i)

The requirements for aerosol generating medical procedures are duplicative[205] and should be eliminated. This would result in a significant simplification and reduction in required PPE under paragraph (f). Furthermore, the requirement to provide PPE in accordance with CDC standards can be relaxed to provide PPE in accordance with this rule. The requirements for supposedly aerosol generating [medical] procedures[206] include to limit who is in the room to essential personnel and to clean surfaces when finished. With the required respiratory protection for covid cases, the limiting of access seems unnecessary. The requirement to clean the room suggests a need to transfer the patient out, possibly, and introduces hygiene theater requirements that I already commented are unnecessary. Consequently, this can also be eliminated.

Physical distancing when employees are wearing respiratory protection should be eliminated,[207] as respirators are adequate protection against the covid virus. In addition, the medical removal provisions[208], while requiring the elimination of the vaccine or prior infection exceptions, and the notification exemption for covid areas (although eliminating that exemption should have limited effect).[209] One change that I would recommend adding is that do it yourself Corsi-Rosenthal Boxes should be encouraged.[210]These are responsible changes that I would recommend. In addition, the training needs to be adjusted to be consistent with the science that the virus is airborne, instead of promoting the use of disinformation from CDC Project Firstline.

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[205]Compare 29 C.F.R. 1910.502(f)(3) with 29 C.F.R. 1910.502(f)(2)
[206] 29 C.F.R. 1910.502(g)
[207] 29 C.F.R. 1910.502(d)
[208] 29 C.F.R. 1910.502(l)
[209] While OSHA exempts workplaces where those patients normally receive services, the requirement to wear a respirator in such areas when those patients are present, combined with the respirator exemption from contact with those patients, would limit when employer notifications are required. Furthermore, requiring an employer to notify about an employee who has covid, when the employee imputed the covid fact into electronic health records or notified the employer, does not have any benefit when quarantine is not appropriate.
[210] *3M scientists: This Corsi-Rosenthal box movement is legit*. (2022, February 24). 3M News Center. Retrieved April 8, 2022, from https://news.3m.com/2022-02-24-3M-scientists-This-Corsi-Rosenthal-box-movement-is-legit

OSHA in request for comment A.2 suggests going further with either using broader requirements that do not state the detail level appropriate or including a safe harbor provision where compliance with the CDC guidance is an acceptable alternative. Neither of these approaches are appropriate. The *Washington Post* describes, in discussing the CDC internal review of its covid response,[211] Doctor Walensky saying "Never [before] has CDC had to make decisions so quickly, based on often limited, real-time, and evolving science."[212] What is recommended for airborne, contact, and droplet based precautions have not changed over the past two plus years during the pandemic. The CDC should ask instead what can be done to prevent mistakes like the retraction of the airborne transmission guidance issued the previous Friday on Monday September 21, 2020,[213] which were based on the science the virus is airborne, as conclusively proved at the National Academies of Science, Engineering, and Mathematics less than a month earlier[214]. Since the science is not rapidly evolving, but has been conclusively determined on transmission, the non pharmaceutical interventions should not be subject to change based on the CDC changing their recommendations unconstrained by the procedural requirements of the Administrative Procedures Act, including notice and comment.

These safe harbor provisions would only have meaning when the CDC modifies recommendations to reduce the precautions recommended for covid, moving towards a pre-pandemic normal that no longer exists. Furthermore, while OSHA may claim restating the

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[211] The CDC Director agreeing to testify under oath and be subject to extensive cross examination at the April 27, 2022 OSHA hearing on the covid rule to protect workers would be more worthwhile, in my view, than conducting this internal review.

[212] Sun, L. H. (2022, April 5). *CDC, under fire for covid response, announces plans to revamp agency*. The Washington Post. Retrieved April 8, 2022, from https://www.washingtonpost.com/health/2022/04/04/walensky-cdc-revamp-pandemic/

[213] Thomas, N. (2020, September 22). *CDC abruptly removes guidance about airborne coronavirus transmission, says update 'was posted in error'*. CNN. Retrieved April 8, 2022, from https://www.cnn.com/2020/09/21/health/cdc-reverts-airborne-transmission-guidance/index.html

[214] Airborne Transmission of SARS CoV 2 A Virtual Workshop. (2020, August 26). National Academies. Retrieved April 8, 2022, from https://www.nationalacademies.org/event/08-26-2020/airborne-transmission-of-sars-cov-2-a-virtual-workshop

requirements would allow more flexibility, I have given OSHA multiple approaches that it can rationally use to approve the final regulation, and the most recent approach goes through the redundancy, eliminating various provisions that likely don't worsen protections for workers. OSHA does not need to use an unprecedented approach.

If OSHA correctly fixed the scope to protect all workers, the same standard should apply that applies to healthcare workers with additional exemptions for wearing a face covering in the vaccine or test emergency temporary standard and the requirement to screen and triage non employees should be the only excluded requirements for non healthcare employees. Those exemptions do not apply in healthcare settings, and medical screening in non healthcare settings is not common. Furthermore, the screening I was describing was based on the assumption that healthcare employees screen patients anyways, so requiring that it be done in a manner that considers the need to implement transmission based precautions is rational.

B. Scope [A.3] [A.6] [C.1.1.A]

The scope of the OSHA regulation, as noted in Section III-B, should cover all workers. OSHA in request for comment A.3 proposes to modify the scope of workers by eliminating the screening out exemption in ambulatory settings and the home healthcare exemption. While I support eliminating these exemptions, my experience on home healthcare suggests that in that context, an individual may not merely be coming part time, but living at a residence for 24 hours a day. In this sort of case, it may make sense to not implement additional requirements. By contrast, if seeing several different customers on a day for an hour, the risk will be drastically different. Nevertheless, merely eliminating these exemptions would not "ensure that all workers

are protected to the extent there is a significant risk", as OSHA proposes to do in its brief. In order to do that, OSHA should cover all industries, not just healthcare.

In request for comment A.6, OSHA stated that it "did not expressly include employers that engage in construction work in hospitals, long-term care facilities and other settings that are covered by the ETS. The construction industry was not included in OSHA's industrial profile for the rule." The document that OSHA cited in explaining why it is holding the hearing, which I submitted[215], mentions that all workers are at grave risk.[216] While the approach that a construction worker inside a hospital is covered while exempting an isolated wing would make sense with a settings based approach as urged by the states before the Supreme Court[217], such a setting based approach is not justified by the data. All workers, not just healthcare workers, are at significant risk from covid.[218]

OSHA in request for comment C.1.1A states it is discussing embedded clinics. Because these embedded clinics do not likely have a separation of air, and people have to go through the facility to get to the healthcare setting, Due to the fact that the virus is airborne, having heightened protections for such an embedded facility is not justified. Instead of using this to categorically exempt such settings, OSHA should cover the setting which the healthcare facility is embedded in to the same extent as the healthcare setting. While OSHA anticipates not covering the facility even if this exemption is eliminated, OSHA should be prioritizing the protection of workers. Nevertheless, if OSHA correctly established the scope of protection at all workers, this question would not arise. In section C.1.2, OSHA asks about costs for teleworking

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[215] https://downloads.regulations.gov/OSHA-2020-0004-1034/attachment_1.pdf
[216] That document does not refer specifically to construction workers, some photos do indicate that it covers healthcare workers. In addition, I used workers throughout that document because workers should have protection.
[217] See Section II-F for more information on that standard
[218] Notably, all workers are still at grave danger from covid-19. That is not the standard in this rulemaking process, however.

employees. I would note that teleworking can be exempted from the covid rule due to the lack of shared air, but decline to discuss the costs.[219]

OSHA anticipates screening for covid symptoms as a cost of the rule. Infection control by screening patients, for example, as to whether or not they have covid-19, should be done to protect patients, even if staff members constantly wear a respirator for all patients. By failing to consider that this cost would be properly incurred by a large number of healthcare employers even if the exemption for healthcare employers was eliminated, OSHA overestimates the cost of compliance. Finally, while Theo Allen concurs that teleworking employers are not properly covered, this comment in response to request for comment C.1.2 is not new.

C. Vaccination Support [A.5.2]

OSHA in request for comment A.5.2 discusses vaccination support. While this support is vital, and the work of experts, such as Doctor Julia Raifman, on why providing support to being vaccinated to workers is vital[220] Nevertheless, OSHA should be mandating that all workers get vaccinated as a condition of employment, in the absence of state governments taking this step to protect their residents and healthcare systems. Vaccine mandates make economic sense, improve productivity, and improve individual health because of the time people spend at work.[221]

Covid-19 is an occupational disease in the sense that the virus transmits easily at workplaces. For healthcare workers, being vaccinated is an issue of professional competency. The need to stay up to date on vaccinations should be emphasized, and the People's CDC

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[219] See Section IX-A for more information on costs.
[220] Raifman, J., Skinner, A., & Michaels, D. (2021, June 30). *Something to celebrate: Delivering vaccines to essential workers*. STAT. Retrieved April 8, 2022, from https://www.statnews.com/2021/07/01/essential-workers-getting-vaccinated-something-to-celebrate/
[221] Dusto, A. (2022, February 22). *Vaccine Mandates: A Public Health Tool for Employers | Johns Hopkins Bloomberg School of Public Health*. Johns Hopkins Bloomberg School of Public Health. Retrieved April 8, 2022, from https://publichealth.jhu.edu/2022/vaccine-mandates-a-public-health-tool-for-employers

recommends that measures be taken to protect healthcare workers, among others, by requiring employers ensure their workforce stays up to date on vaccination. Getting a covid vaccination should be supported by giving workers paid time off, requiring employers to inform employees about the benefits, and provide reasonable time off, in addition to sick leave for the relatively mild reactions to the vaccination, which is why the paid time off for vaccination side effects will likely be unneeded for most workers. If the side effects of vaccination require time off, in an environment of uncontrolled spread of epidemic covid, the time off from infection would be immense.

We also support requirements for employers to support employees staying up to date on vaccination. Given that the vaccines appear likely to require administration more than annually, this should be implemented. Furthermore, while OSHA is considering the alignment with the Center for Medicare & Medicaid Services (CMS) rule on vaccination, the employer support for vaccination should not be conditioned on an independent vaccine mandate. I support the four hours of travel time for vaccination when needed and sick leave for reactions to vaccines. Nevertheless, as an expert letter, signed by dozens of public health experts, clinicians, and scientists makes clear,

> *"There are other drawbacks to a vaccines-only strategy. Countries which tolerated high transmission have seen rises in both covid-specific and all-cause mortality, healthcare worker shortages, and repeated lockdowns to control surges in case numbers. Countries which suppressed transmission early saw reduced mortality and less economic damage. … High levels of transmission also create a negative feedback loop, whereby important public health measures such as test, trace, isolate and support systems become overwhelmed, making them less effective, further fuelling transmission."*[222]

[222] Covid-19: An urgent call for global "vaccines-plus" action | The BMJ found at https://www.bmj.com/content/376/bmj.o1

D. New Variant [A.9] [B.5]

In request for comments A.9, OSHA is asking whether a variant which has sufficient genetic drift to be called something, such as a "COVID-22", whether this rule should cover that. The continued spread of COVID-19 should be expected to produce new variants, and they would have the same mode of transmission. There is no guarantee that the new variants would be less virulent, although they would be more transmissible due to the need to outcompete existing variants.[223] While this rule should cover all strains of SARS-CoV-2, occupational measures and public health measures should be taken to protect healthcare workers and others from the dangers of new variants of COVID-19. The thought that variants will inevitably be milder is also a mistake.

> *"The notion that viruses will evolve to be less virulent to spare their hosts is one of the most persistent myths surrounding pathogen evolution. … If severity manifests late in infection, only after the typical transmission window, as in SARS-CoV-2, but also influenza virus, HIV, hepatitis C virus and many others, it plays a limited role in viral fitness and may not be selected against. Forecasting virulence evolution is a complex task, and the lower severity of Omicron is hardly a good predictor for future variants. The prospect of future VOCs featuring the potentially disastrous combination of the ability to reinfect due to immune escape along with high virulence is unfortunately very real."*[224]

In request for comment B.5, OSHA is requesting data on health effects and transmission rates of new variants, such as BA.2. As has been stressed, the variant is more transmissible compared to previous variants. Furthermore, on a public health level, including in occupational health, the more transmissible variant normally will be the most dangerous in terms of creating more hospitalizations and fatalities. What has been seen is that the vaccines alone approach has

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[223] Markov, P.V., Katzourakis, A. & Stilianakis, N.I. Antigenic evolution will lead to new SARS-CoV-2 variants with unpredictable severity. *Nat Rev Microbiol* (2022). https://doi.org/10.1038/s41579-022-00722-z

[224] Markov, P.V., Katzourakis, A. & Stilianakis, N.I. Antigenic evolution will lead to new SARS-CoV-2 variants with unpredictable severity. *Nat Rev Microbiol* (2022). https://doi.org/10.1038/s41579-022-00722-z

not been successful. As stated in an open letter from a group of public health experts, clinicians, and scientists:

> *"The high transmissibility and degree of immune escape by the delta and omicron[225] variants means sustained protective population immunity is unlikely to be achieved with the current vaccines based on the original strain. Compared to delta, omicron is much more likely to infect those who were vaccinated or exposed to previous SARS-CoV-2 variants, suggesting significant immune escape. Widespread transmission brings a degree of unpredictability to the pandemic response. High transmission risks more rapid adaptation of SARS-CoV-2, with outcomes that include increased transmissibility (seen with α, delta, and omicron), increased antibody immune escape (β and omicron) or greater pathogenicity (delta and α)."*[226]

This letter references a study from Ontario, Canada where notwithstanding increased vaccination and infections happening in younger individuals, virulence was increased for the delta variant, which represented a substantially increased public health risk when immune escape and increased transmissibility were considered.[227]

In request for comment C.5, OSHA discusses the assumptions on vaccine effectiveness as well as the frequency, the severity, and the distribution of covid cases. OSHA should not

E. Tailoring [A.4]

OSHA discusses in request for comment A.4 tailoring the requirements in areas where healthcare workers are not reasonably expected to encounter people who are suspected of having or confirmed to have covid-19. My view is that OSHA should not only be covering healthcare workers, but should be covering all workers to the maximum extent authorized under the OSH Act.[228] My previous submissions have suggested that it is possible to weigh risk and adjust protections, but in order to do that, guardrails need to be imposed.

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[225] As used in this letter, "Omicron" refers to the BA.1 variant.
[226] Covid-19: An urgent call for global "vaccines-plus" action | The BMJ found at https://www.bmj.com/content/376/bmj.o1
[227] Evaluation of the relative virulence of novel SARS-CoV-2 variants: a retrospective cohort study in Ontario, Canada | CMAJ found at https://www.cmaj.ca/content/193/42/E1619
[228] *NFIB v. OSHA* may foreclose OSHA from regulating covid in all workplaces.

With a suspected or confirmed covid case, the full protections against covid should be implemented, regardless of community transmission rate. In the United Kingdom, using fluid resistant surgical masks has been associated with a stark increase in covid cases among healthcare workers.[229] Furthermore, requiring respiratory protection was critical in stopping the Royal Melbourne, Australia, outbreak.[230] When someone is treating a patients with suspected or confirmed covid, that likely means that they are breathing the same air as someone who is at least suspected of being contagious with covid-19. Thus, not wearing respiratory protection would mean at least a significant probability would exist of inhaling SARS-CoV-2.

The first step is to screen and triage individuals to ask whether a reasonable expectation of being a person who is confirmed or suspected of being infectious with covid. While I suggest allowing the use of medical judgment, in order to be effective, the actual screening needs to occur as quickly as possible when a person enters the facility. Merely having someone wait in a waiting room furthers the spread of the virus, and should be avoided. Given the increased wait times due to epidemic covid, as discussed in Section VI, this may be more difficult to administer. Consequently, in any area where you are unable to properly screen or triage patients for covid, reductions in mitigation should not occur.

Second, any mitigation should be done emphasizing the relative risk of getting the virus. Medical removal provisions, for example, should not be restricted in this manner. The medical removal provisions consist of mandatory contact tracing which triggers paid time off to quarantine for workplace exposures and paid sick leave. If no reasonable expectation of getting covid at work existed in a healthcare setting, then the exposure notifications would be unlikely to

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[229] Van der Meer, J. W. (2021). Editor's evaluation: Efficacy of FFP3 respirators for prevention of SARS-COV-2 infection in healthcare workers. https://doi.org/10.7554/elife.71131.sa0

[230] McCauley, D. (2020, July 27). *Doctors fear 'unacceptable risk' on Melbourne coronavirus ward without specialist N95 masks*. ABC. Retrieved April 6, 2022, from https://www.abc.net.au/news/2020-07-28/doctors-at-melbourne-hospital-say-ppe-for-covid-19-inadequate/12497390

be needed, which means that form of medical removal would be unlikely. Furthermore, if someone who has symptoms of covid does not get sick time, it means that workers with covid will come to work and endanger others[231]. Notably, this applies in non healthcare settings as much as in healthcare settings.

In addition, OSHA asks about an outbreak. While I decline to define what is an outbreak, the precautions that should be implemented in an outbreak should be based on the requirements to protect healthcare workers if they were exposed to a covid patient. Looking at the hierarchy of controls, it is assumed that PPE is the least effective tool. Elimination is unviable today due to the refusal to implement a public health elimination strategy. Substitution, such a source control, such as stopping someone from breathing, is not acceptable, and the vaccines are not acceptable alternatives. Engineering solutions are inadequate to control the close range airborne transmission of covid, and are not effective enough against longer distance airborne transmission. And administrative controls are not being implemented. Because the source of covid is human breathing, source control If an outbreak occurred, the requirements that should be triggered need to include, at a minimum, universal respiratory protection until the outbreak ends.

VI. Staffing Consequences of Proposal [B.10]

OSHA in request for comment B.10 asks for the impact of this rule, such as the effects on staffing retention. I notes that the proposed rule is not a comprehensive, equity focused, public health approach that is based on the fact that uncontrolled transmission of covid-19 is harming our healthcare system.

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[231] Hussain, S. (2022, January 27). *Without COVID testing, sick workers are staying on the job*. Los Angeles Times. Retrieved April 6, 2022, from https://www.latimes.com/business/story/2022-01-26/covid-testing-rapid-tests-access-sick-leave-cdc-quarantine-workplace-risks

Healthcare workers have resigned because their employers have failed to protect them. The increase in covid cases has led to surges of cases that have been seen with subsequent waves of the virus, from Alpha (B.1.1.7) to Delta (B.1.617.2) to Omicron (B.A.1) which will likely be followed by B.A.2. The increase in cases has led to an increase in hospitalizations and people to postpone care. As this happens, deaths at home increase, as well as longer response times for ambulances. Emergency rooms have seen the wait increase from 22.5 minutes pre-pandemic to 62 minutes in 2021,[232] more than doubling wait times. With these conditions, healthcare workers are forced to handle more patients, which causes unsafe staffing levels.

This unsafe staffing means more deaths for patients. One study found "the adjusted odds ratio for in-hospital death in the highest quintile of burden was 1.46 (95% CI, 1.07-2.00) compared to all other quintiles."[233] Another cause of increased patient mortality is boarding in the emergency department, as the American College of Emergency Physicians notes, means not only increased mortality. "Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs."[234]

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[232] Ranney, M. *"Lessons from the Frontline: Covid-19's Impact on American Health Care."* (2022, March 2). https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Ranney_OI_2022.03.02.pdf

[233] Block, B. L., Martin, T. M., Boscardin, W. J., Covinsky, K. E., Mourad, M., Hu, L. L., & Smith, A. K. (2021). Variation in covid-19 mortality across 117 US hospitals in high- and low-burden settings. *Journal of Hospital Medicine*, *16*(4). https://doi.org/10.12788/jhm.3612

[234] Davis, J. (2021, August 26). Emergency Department "Boarding" At Seemingly All-Time High Levels. American College of Emergency Physicians. Retrieved April 8, 2022, from https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggs-articles/regs--eggs---august-26-2021/

Insufficient staffing leads to closing of emergency rooms[235] and reduced pharmacy hours or closures, including at chain pharmacies,[236] postponement of essential procedures[237] longer times to discharge patients into hospitals which means ambulances take additional minutes,[238] and more. The worse consequence is staff leaving.[239] With the increase in long covid, it is overwhelming primary care. Pharmacies have seen more duties with covid tests and vaccinations, as well as a shortage of workers to such an extent that Walgreens and CVS have more vacancies for pharmacists than we have graduating pharmacists in the United States in 2022. This means that people are coming in more acute status to the emergency room, which means heightened workloads.

And unsafe staffing levels, along with covid disinformation, leads to violence against healthcare workers at increased levels. This causes more workers to leave clinical practice and aggravates the dangers that healthcare workers face. This vicious cycle will likely continue as long as uncontrolled covid continues. Safe staffing, promoting mental health, increasing residency slots, increasing nurse educator pay to create more slots for nursing students, and other tools are not enough to fix the problem. While they have a role, as does the OSHA proposed rule,

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[235] Taylor, D. (2021, August 24). *Memorial Hermann hastily announces closure of three ER's*. Houston Chronicle. Retrieved April 8, 2022, from https://www.houstonchronicle.com/neighborhood/humble-kingwood/article/Memorial-Hermann-hastily-announces-closure-of-16409359.php?utm_source=dlvr.it&utm_medium=twitter

[236] Holpuch, A. (2022, January 15). *CVS, Walgreens Announce Weekend Closures as Omicron Cases Soar*. The New York Times. Retrieved April 8, 2022, from https://www.nytimes.com/2022/01/15/world/cvs-walgreens-omicron.html

[237] Jambhekar, A. (2021, August 25). https://twitter.com/AjvictoryMD/status/1430629204220071936?s=20&t=ns9wo9n0ochuwCVbSUgHBQ

[238] Despart, Z. (2021, August 26). *Houston ambulances face lengthy wait times at ERs as COVID patients flood hospitals*. Houston Chronicle. Retrieved April 8, 2022, from https://www.houstonchronicle.com/news/houston-texas/houston/article/Houston-ambulances-face-lengthy-wait-times-at-ERs-16411446.php#photo-21392128

[239] Holcombe, M., Hill, E., & Dolan, L. (n.d.). *'I think we already broke': Mississippi's nurses are resigning to protect themselves from Covid-19 burnout*. CNN. Retrieved April 8, 2022, from https://edition.cnn.com/2021/08/25/us/mississippi-covid-nurse-strain/index.html?utm_medium=social&utm_source=twCNN&utm_content=2021-08-26T11:57:17

these tools, this will not solve the problem. Any solution to staffing retention must begin with a public health focus on reducing transmission of covid-19.

As stated in the World Health Network article, "[t]he belief that infections do not matter as long as hospitals are not full is not sustainable either. First, when hospitals are running at almost full capacity, it exhausts health workers (including outpatient care) and puts them even more at risk of getting infected, further adding to the health system struggle. Then, a hospital-focused vision does not consider the individual and societal impact of the infection consequences, such as long Covid and potential sequelae." We have data from the United Kingdom, reported by in *The Guardian*[240] suggesting that 2.4% of the United Kingdom population, which is one in forty people, were experiencing post covid infection symptoms more than 45 days after infection with 45% of those surveyed suspecting that they experienced covid over a year ago.[241] In addition, a year after hospitalization, only one third of individuals were reported to have made a full recovery.[242]

Understandably, healthcare workers have went on strikes recently over staffing in Daly City Hospital in California,[243] notwithstanding California's safe staffing law.

Since this plan does not implement a comprehensive public health strategy that prioritizes reducing the transmission of covid-19 in the community, this plan has, at best, a negligible

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[240] Long Covid could create a generation affected by disability, expert warns | Long Covid | The Guardian found at https://www.theguardian.com/society/2022/mar/23/long-covid-could-create-a-generation-affected-by-disability-expert-warns

[241] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3march2022

[242] Many Covid hospital patients do not feel fully recovered year later – study | Long Covid | The Guardian found at https://www.theguardian.com/society/2021/dec/16/many-covid-hospital-patients-do-not-feel-fully-recovered-year-later-study

[243] *Nurses at Daly City Hospital Hold 1-Day Strike Over Staffing Issues*. (2022, March 30). NBC Bay Area. Retrieved April 8, 2022, from https://www.nbcbayarea.com/news/local/nurses-at-daly-city-hospital-hold-1-day-strike-over-staffing-issues/2850743/?_osource=SocialFlowTwt_BAYBrand

impact on the grave occupational hazard of burnout in healthcare workplaces. According to the National Institute for Occupational Safety and Health, "Worsening staffing issues are now the biggest stressor for clinicians."[244] The article continues to cite a behavioral scientist[245] Thomas Cunningham, who emailed JAMA "The evidence shows that health workers have been leaving the workforce at an alarming rate over the past 2 years."[246] In fact, surveys indicate that one "quarter of clinicians said they planned to leave primary care within 3 years in Etz's February survey. The Coping With COVID study predicts a more widespread clinician exodus: in the pandemic's first year, 23.8% of the more than 9000 physicians from various disciplines in the study and 40% of 2301 nurses planned to exit their practice in the next 2 years."[247] This does not only affect doctors, but nurses as well." Nurses who said they intended to leave their positions within 6 months cited 3 main drivers in an American Nurses Foundation survey: work negatively affecting their health and well-being, insufficient staffing, and a lack of employer support during the pandemic."[248]

This shortage can be seen due to three interrelated causes in the United Kingdom.

> *"On Wednesday evening, the crisis became so acute in Hampshire and the Isle of Wight that its chief medical officer urged relatives of patients well enough to be discharged to collect them immediately – even if they were still testing positive for coronavirus.*
> *Dr Derek Sandeman, of the Hampshire and Isle of Wight Integrated Care System, revealed that almost every hospital in the two counties was full, and said the number of people with Covid-19 being cared for in hospitals across the area was 650 – more than 2.5 times higher than in early January. He added*

[244] Abbasi, J. (2022). Pushed to their limits, 1 in 5 physicians intends to leave practice. *JAMA*. https://doi.org/10.1001/jama.2022.5074
[245] Notably, the CDC has consistently ignored behavioral science in establishing public health policies
[246] Abbasi, J. (2022). Pushed to their limits, 1 in 5 physicians intends to leave practice. *JAMA*. https://doi.org/10.1001/jama.2022.5074
[247] Abbasi, J. (2022). Pushed to their limits, 1 in 5 physicians intends to leave practice. *JAMA*. https://doi.org/10.1001/jama.2022.5074
[248] Abbasi, J. (2022). Pushed to their limits, 1 in 5 physicians intends to leave practice. *JAMA*. https://doi.org/10.1001/jama.2022.5074

> *that 2,800 staff working for local NHS organisations were off sick, half of which absences were due to Covid-19.*
> *'With staff sickness rates well above average, rising cases of Covid-19 and very high numbers of people needing treatment, we face a perfect storm – but there are some very specific ways in which people can help the frontline NHS and care teams,' said Sandeman."*[249]

Having family members collect patient belongings, the recommendation is not a solution to address burnout. While many nurses were thinking of leaving before the pandemic started, 39% workers are experience burnout because of short staffing, 36% saw acure patients leave the emergency room, indicating an inability to comply due to staffing with the Emergency Medical Treatment and Active Labor Act, 37% saw surguries rescheduled, with 42% saying updating paperwork and conducting discharges were very burdensome, according to a study.[250]

Soumya Rangarajan tweeted "Just gonna say, with 50-60 ED holds in our emergency department and running out of nursing staff on the floor, even with our #COVID19 numbers flat in the teens...we ain't got room for this. Hospitals don't have room for individualized risk taking."[251]. This was in response to Doctor Laura Wen commenting that superspreader events like the Gideon Dinner are the new normal. The Executive Director of No License for Disinformation, emergency room doctor Nick Sawyer, authorized me to say that is his statement.

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[249] Gregory, A. (2022, April 6). *Families asked to take in Covid-positive loved ones as NHS faces 'perfect storm'*. The Guardian. Retrieved April 8, 2022, from https://www.theguardian.com/world/2022/apr/06/nhs-enormous-strain-england-trusts-declare-critical-incidents

[250] Siwicki, B. (2022, March 24). *Report: 90% of nurses considering leaving the profession in the next year*. Healthcare IT News. Retrieved April 8, 2022, from https://www.healthcareitnews.com/news/report-90-nurses-considering-leaving-profession-next-year?utm_campaign=601fc72102945d0001adbb35&utm_content=6240a7278fbb5600019a6387&utm_medium=smarpshare&utm_source=twitter

[251] Rangarajan, S. (2021, April 7). https://twitter.com/soumya_goblue/status/1512221779200290817?s=20&t=ns9wo9n0ochuwCVbSUgHBQ

VII. Data Requested

A. Workers Time Off [B.1]

OSHA asks for the average number of days workers have taken from work resulting from a COVID-19 infection or quarantine and the percentage of healthcare workers who have taken days off of work due to a COVID-19 infection or quarantine in request for comment B.1 since August of 2021. What we know is healthcare workers and others are getting infected and quarantined, although this has lessened after the new CDC guidance came out on shortening isolation periods to unsafe durations. I do not have additional data to provide and decline to perform the research. Other interested parties should be in a better position to provide OSHA with this data.[252]

B. Health Effects and Concerns [B.2] [B.3] [B.4]

OSHA in request for comment B.2 requests "health effects for fully vaccinated employees, and fully vaccinated and boosted employees, who test positive for COVID-19 including data on days away from work, hospitalizations, long COVID, and fatalities". In request for comment B.4, OSHA requests "the rates of infection, long COVID, hospitalization, and death among healthcare workers compared to these rates among the general adult population". And in request for comment B.3, OSHA requests "the percentage of healthcare workers who are at an elevated risk of severe COVID-19 infection". SARS-CoV-2 is an occupational disease in that it spreads through the workplace. Healthcare workplaces where covid patients are seen and respiratory protection is not worn are at extremely high risk, but the same cannot be said about

[252] Various employers and unions, whom I expect to testify at the OSHA hearing, should have this sort of data.

other healthcare workers. Essential workplaces are actually at higher risk compared to healthcare workplaces in terms of worker harms from covid in terms of mortality.[253]

Nevertheless, a premise has been suggested is that the elevated risk of severe covid-19 infection may affect only certain demographics. First, this ignores the need for equity, which considers the disadvantages that vulnerable communities have. Second, this argument is based on the fact that the damage from covid only affects select groups. COVID-19 has been shown to cause permanent damage to a large percentage of people, including those who are younger and lack the same comorbidities that make hospitalization or death more likely. Indeed, a covid-19 infection can create the vulnerabilities that make someone more vulnerable to a "severe" outcome if reinfected.

According to the Institute for Health Metrics and Evaluation at the University of Washington, while the risks of long covid may be significant, women are nearly twice as likely as men to get long covid.[254] In 2020 and 2021, 9.8 million Americans were estimated to have received long covid, of which, 91% of cases did not include hospitalization. This was estimated to have an average disability rate equal to complete hearing loss and severe traumatic brain injury, with an average weight of 0.21. Long COVID would disproportionately affect the healthcare workforce because over three quarters of the healthcare workforce is female.[255]

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[253] See Section III-B for more information on that standard

[254] https://www.nationalacademies.org/event/03-21-2022/docs/DE8B0EADD608B740B4285543CF6A14456483E29D5B57

[255] https://www.census.gov/library/stories/2019/08/your-health-care-in-womens-hands.html

The consequences of long covid are varied and include cognitive defects,[256] increased risks of heart disease, [257] and other cardiovascular disease risks increasing[258], neurological changes including brain size decreasing, even when excluding cases resulting in hospitalizations,[259] more suffer organ damage and loss of cognitive function)Severe long covid occurs in about 10-15% of people who are afflicted by very debilitating problems such as cardiovascular events (3% for non-hospitalized "mild" cases[260]), brain fog, neurological problems, and chronic conditions including diabetes[261], and early onset Alzheimer's and Parkinson's disease.

C. Vaccination Data [B.6] [B.7] [B.8]

In requests for comment B.6, OSHA asks about "the vaccination rates among healthcare workers, including the rates of healthcare workers who are fully vaccinated and boosted". This rate is substantially higher among healthcare workers compared to the general population. OSHA in request for comment B.7 and B.8 asks about the degree of protection from prior infection and vaccination, as well as the duration of this protection. The evidence has come to suggest that prior infection (if it does not result in death or other permanent damage from covid, which is extremely common) provides some protection, and the vaccines provide more protection.

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[256] Adam Hampshire et al, Cognitive deficits in people who have recovered from COVID-19, https://doi.org/10.1016/j.eclinm.2021.101044

[257] Saima May Sidik. "Heart-disease risk soars after COVID—even with a mild case." Nature 602, 560 (2022) doi: https://doi.org/10.1038/d41586-022-00403-0 Heiss, Rafael, et al. "Persisting pulmonary dysfunction in pediatric post-acute Covid-19." (2022).

[258] Long-term cardiovascular outcomes of COVID-19 | Nature Medicine found at https://www.nature.com/articles/s41591-022-01689-3

[259] G. Douaud, S. Lee, F. Alfaro-Almagro, et al. SARS-CoV-2 is associated with changes in brain structure in UK Biobank. Nature (2022). https://doi.org/10.1038/s41586-022-04569-5

[260] Y. Xie, E. Xu, B. Bowe, et al. Long-term cardiovascular outcomes of COVID-19. Nat Med 28, 583–590 (2022). https://doi.org/10.1038/s41591-022-01689-3

[261] T. Sathish, N. Kapoor, Y. Cao, RJ Tapp, P. Zimmet 2021, Proportion of newly diagnosed diabetes in COVID-19 patients: a systematic review and meta-analysis, Diabetes, obesity & metabolism, 23, 3, 870-874. https://dx.doi.org/10.1111/dom.14269

Nevertheless, where is the data on breakthrough cases that OSHA is asking about? The CDC has actually discontinued reporting on breakthrough cases that do not result in hospitalization on May 1, 2021.[262] This appears to have been done because only cases resulting in hospitalization warranted study due to an increase in breakthrough cases. This is similar to saying that we don't need to record cases. The failure to record covid cases has hampered the response to the pandemic.[263] While some data exists, it is incomplete at best.

VIII. Recordkeeping [A.7]

OSHA in request for comment A.7. discusses retaining covid-19 logs for one year. I decline to take a position on this measure.

IX. Costs and Benefits

A. Costs of Infection [C.1]

In request for comment C.1, OSHA discusses the industry profile. OSHA asks about whether it should consider a settings based approach to determine the scope of workers protected by the covid rule. OSHA should also count the nearly one hundred million worker that this rule does not cover and how many premature deaths, hospitalizations, and long covid infections will be caused by the failure to protect workers outside of healthcare. Sadly, the number of workers who lose their lives from covid exposures at work has not been documented, but may exceed the

[262] Stein, R. (2021, May 27). *Why Scientists Worry About The CDC's Approach To COVID Breakthrough Infections : Shots - Health News*. NPR. Retrieved April 8, 2022, from https://www.npr.org/sections/health-shots/2021/05/27/1000933529/cdc-approach-to-breakthrough-infections-sparks-concerns

[263] Banco, E. (2021, August 25). *Holes in reporting of breakthrough Covid cases hamper CDC response*. Politico. Retrieved April 8, 2022, from https://www.politico.com/news/2021/08/25/cdc-pandemic-limited-data-breakthroughs-506823

total number of workers who died in the workplace, as reported by the Bureau of Labor Statistics.[264]

OSHA fails to properly consider the costs of the workforce, relying on Emily Oster based economic analysis that focuses on individual risk and has been used to dismantle public health protections that actually protect people against covid.[265] These do not merely include the losses from quarantine or isolation, but include the longer term costs. A percentage of individuals infected with covid get hospitalized, and some have to reduce hours or leave their jobs due to long covid, not counting those who die. Instead of considering that long COVID could create "a generation of disability", [266] and the shortages of workers that is caused by covid, OSHA claimed billions of dollars of unreclaimed costs would have been imposed on employers had the vaccine or test emergency temporary standard been implemented. This cost benefit analysis is the same analysis that the Great Barrington Declaration relies upon.

OSHA, while looking for cases, illness, hospitalization, and death in the healthcare workforce, fails to request data on other occupational fields, which should be protected by this rule. While OSHA is looking at in request for comments C.5.2 long term effects from long covid, hospitalization, and supposedly shorter illness, it identifies three factors. First, OSHA identifies the variants. Variants are not necessarily likely to be milder. If the view of epidemic covid means ignore the costs of avoiding infection, does it mean ignoring the consequence of that decision in the form of decimating the healthcare workforce and overwhelming providers to even higher

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[264] Barab, J. *Workers Who Died of COVID Remain Invisible to Feds*. (2021, December 16). Confined Space. Retrieved April 8, 2022, from https://jordanbarab.com/confinedspace/2021/12/16/workers-who-died-of-covid-remain-invisible-to-feds/

[265] Cartus, A., & Feldman, J. (2022, March 22). *Motivated Reasoning: Emily Oster's COVID Narratives and the Attack on Public Education • Protean Magazine*. Protean Magazine. Retrieved April 6, 2022, from https://proteanmag.com/2022/03/22/motivated-reasoning-emily-osters-covid-narratives-and-the-attack-on-public-education/

[266] Long Covid could create a generation affected by disability, expert warns | Long Covid | The Guardian found at https://www.theguardian.com/society/2022/mar/23/long-covid-could-create-a-generation-affected-by-disability-expert-warns

burdens? Instead of increased vaccination, considering that the vaccines were inequitably distributed and this means healthcare providers in vulnerable communities are more likely to be overwhelmed?

And finally, OSHA considers improved treatments. If the goal is to have better treatments in the hospital, that is one solution. But if preventing hospitalizations is a goal, then do we have adequate treatments? The BA.2 variant meant that multiple outpatient treatments were neutralized. Palaxoid is subject to many contraindications, which means it can't be prescribed to everyone, requires healthcare workers to make an individual determination as to the costs and benefits, and is in very short supply. This means added burdens on already overwhelmed pharmacists and healthcare workers.

B. Costs are Net Benefits [C.2.2.1] [C.2.2.3]

OSHA in request for comment C.2 asks about costs. OSHA asks about the one time costs of initial training, rule familization, and covid plan development. For healthcare employers, who had to comply with the healthcare emergency temporary standard, these costs were already incurred and any cost of removing measures that don't protect against covid-19 will not be a cost on employers that would have been incurred had the final rule not been issued.

Furthermore, the costs in a respiratory protection program can be reduced. If OSHA modifies the program to eliminate the medical screening portion that has been shown over the past two years to not be useful in protecting workers in environments such as healthcare and other locations where you don't have concerns such as heat stress, and makes other modifications to prioritize the fit test, will be less onerous on employers. OSHA could also include using solutions to eliminate the mask fit, such as a mask brace. In addition, the benefits of ventilation

protect against worsening air quality caused by climate change and improve productivity, as shown on standardized tests in schools.

The continuing costs of PPE to protect against covid and respirators as separate costs is mistaken. Acknowledging that covid is airborne means that respiratory protection is adequate protection against covid-19 and all of its variants. Furthermore, the cost of elastomeric respirators are reduced compared to disposable N95 masks,[267] even if considering that continuous respirator use should be a standard measure to protect workers. Changing respirators after each patient means temporarily unmasking in a covid hot zone is dangerous and does not protect workers, which is why that should be discontinued[268].

Medical removal protection is, economically, similar to mandatory sick leave when someone is infectious with covid. Paid sick leave has shown benefits outweighing costs in terms of worker productivity and lower time missed by other workers in the workplace. According to the Kaiser Family Foundation, three out of ten lower income workers came to work because they did not have paid sick leave.[269] To protect workers, the step of mandatory paid leave for all workers should be implemented.

Consequently, this should be a net benefit and implemented to protect our workforce. These benefits outweigh the cost even as tax benefits are eliminated, as OSHA is considering in adjusting the ancillary costs in request for comment C.2.3. Nevertheless, I decline to comment on this economic analysis further.

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[267] Ives, J. (2020, June 12). *Reusable elastomeric respirator masks offer a cost-effective option for health care workers*. News Medical. Retrieved April 8, 2022, from https://www.news-medical.net/news/20200612/Reusable-elastomeric-respirator-masks-offer-a-cost-effective-option-for-health-care-workers.aspx

[268] Consequently, I am suggesting this is not contingency standards of personal protective equipment.

[269] Gounder, C., & Wen, L. (2022, March 31). *Opinion | How can we put covid behind us without guaranteed paid sick leave?* The Washington Post. Retrieved April 8, 2022, from https://www.washingtonpost.com/opinions/2022/03/31/how-can-we-put-covid-behind-us-without-guaranteed-paid-sick-leave/

Even in request for comment C.5, where OSHA asks about the costs of small healthcare providers, the costs of epidemic covid on small healthcare providers and the benefits of protecting their workers need to be considered. Being overwhelmed with patients and short on staff may mean being able to charge more, but it means limited time with each patient, and failure to provide adequate care.

C. Consider Workforce of Age 65-74 [C.2.2A]

OSHA is considering in request for comment C.2.2A including age 65-74 year old healthcare workers in the report. While we encourage this to be done, and including this subgroup of workers will likely produce more accurate results, which show that the benefits of protecting workers clearly outweigh the costs imposed.

D. Sources [C.3] [C.2.2B]

OSHA is looking for sources on benefits, including workers who OSHA anticipates covering, who are healthcare workers. OSHA is also looking for data on healthcare workers data to adjust the 65-74 year old range. OSHA should consider using excess mortality over the course of the pandemic instead of merely accepting the hospitalization data or fatality data that has been decreased by the CDC to only include confirmed deaths and include lagging delays. While OSHA may have based the vaccine or test emergency temporary standard[270] on this sort of data, OSHA needs to consider the CDC does not have complete data. Nevertheless, deciding what is counted is very important.

[270] Petitioner Theo Allen requested a hearing on that standard as well, which OSHA was statutorily required to hold before unlawfully withdrawing that rule based on *NFIB v. OSHA*.

While the long covid data is difficult to track and covid casecounts are straightforward, even though negative tests should also be tracked, we have seen significant changes in how they count hospitalizations and deaths. I recommend a uniform approach for this date. That should include that if test positivity is not reported, the test positivity rate should be treated as 100% for calculating community transmission rates. In terms of hospitalizations, I recommend using patients who have been admitted who have been placed into covid isolation as required by the rule, even if the patient subsequently exits isolation due to no longer being infectious.. This is important to correct for significant underreporting due to lax definitions. These sorts of definitions are being to say covid is mild

The administration looked to modify the definition by not counting incidental cases.[271] In New Hampshire, the state redefined on Tuesday March 29, 2022 to have hospitalizations only count when treatment for remdesivir or dexamethasone is occurring.[272] Nevertheless, the factors executive vice president of the New Hampshire Medical Society James Potter emphasize include a "challenge to differentiate between a primary COVID-19 diagnosis and an underlying condition that has been ignored or delayed – when the patient tests positive for COVID-19 and needs immediate treatment for the chronic condition. He sees it as an additional diagnostic marker, not a substitution for other metrics." [273]

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[271] Bacon, E. *Biden officials trying to recalculate U.S. covid-19 hospitalizations*. POLITICO. (2022, February 7). Retrieved April 8, 2022, from https://www.politico.com/news/2022/02/07/biden-covid-hospitalization-data-recalculate-00006341?utm_campaign=KHN%3A+First+Edition&utm_medium=email&_hsmi=203241528&_hsenc=p2ANqtz-8bXkRVUholx8DsBU_zTWHyn4BfMedeYs-RurX7gnEGEwVC-q1emdU7Ujc-Y5xcJF7BTMdAeF7MTv2PmmfK3V9Nrnh5KEjVEcrrrwzKSU0WV3pbtJ4&utm_content=203241528&utm_source=hs_email

[272] Timmins, A. (2022, March 31). *State and hospitals don't see eye to eye on counting COVID hospitalizations*. NHPR. Retrieved April 8, 2022, from https://www.nhpr.org/health/2022-03-31/nh-and-hospitals-dont-see-eye-to-eye-on-counting-covid-hospitalizations

[273] Timmins, A. (2022, March 31). *State and hospitals don't see eye to eye on counting COVID hospitalizations*. NHPR. Retrieved April 8, 2022, from https://www.nhpr.org/health/2022-03-31/nh-and-hospitals-dont-see-eye-to-eye-on-counting-covid-hospitalizations

Often, the condition has been delayed care because of a prior surge of covid limiting capacity of care. The hospitals emphasize "all COVID-19 patients increased demand on hospitals because they sometimes need their own rooms, remain in ICUs for days, and require staff to don and doff protective equipment each time they enter their rooms to reduce transmission, a costly and time-consuming process."[274] Nevertheless, this is somewhat misleading. First, covid patient require airborne isolation, but only while infectious. This means[275] requiring their own room. While the mention of the lengthy donning and doffing of PPE is mentioned, the elimination of contact precautions for all covid patients, while recommended because it is hygiene theater,[276] would disappear. Yet, covid hospitalizations also mean the denial of visitors due to airborne precautions, and the labor intensive, but life saving proning requires a team of overburdened healthcare workers.[277]

X. Conclusion

One story, of Advocacy Trinity Health, tells the shortcomings, but also the promise if we take the steps to protect healthcare workers. Worn down by the relentless surges, many employees retired or took positions that don't involve acute care. "Our patients are pretty sick coming in the door, because they haven't been able to afford care and they haven't seen a physician in years," emergency nurse Berenice Zavala said. New nurses time onboarding doubled, and one emergency nurse had to cover twenty-one beds by Halloween.

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[274] Timmins, A. (2022, March 31). *State and hospitals don't see eye to eye on counting COVID hospitalizations*. NHPR. Retrieved April 8, 2022, from https://www.nhpr.org/health/2022-03-31/nh-and-hospitals-dont-see-eye-to-eye-on-counting-covid-hospitalizations

[275] It is possible to have covid positive patients share rooms.

[276] See Section IV-B for more information on this.

[277] *The Art of Proning*. (2021, May 7). Johns Hopkins Medicine. Retrieved April 8, 2022, from https://www.hopkinsmedicine.org/news/articles/the-art-of-proning

Patients delayed coming because of fears of getting covid whale others had six month waits to see primary care. Opioid cases surged, and where was the off ramp. Transfers were impossible and Illinois restricted ambulance diversion. "The waiting room swelled with on-edge, fed-up patients who took their anger out on the nurses." And Ed Yong in *The Atlantic* writes "The moral distress of being unable to sufficiently care for their patients is among the worst hardships that health-care workers have been forced to endure. 'To feel like you aren't able to give your patients the best, because the situation is poor, takes a deep toll,' Anderson said.

Even with a surge subsiding after Christmas, wait times ran eleven hours on two Sundays. With COVID set to be a permanent fixture in our lives, more surges and variants are possible. The hospital will have to deal with people whose care was postponed amid the surge and those with long-term problems because of their run-ins with COVID. Meanwhile, the staffing shortages that long preceded Omicron's arrival will remain. A small community hospital will struggle to attract staff in a way that a larger, better-funded institution won't. Nursing- and medical-school applications are up, but training the next generation will take several years."[278]

Advocacy Trinity started hiring licensed practical nurses, started assigning groups of patients to nursing teams, and focusing on protecting staff mental health, as well as retention bonuses. Advocacy Trinity has gone outside its walls to vaccinate, is leading a project to bring back primary care doctors and community health workers, and teaming up with social service agencies. These public health tools should not fall on our hospitals, but public health cannot be resilient with epidemic covid. What is clear, however, is that unless OSHA acts boldly to protect all workers, and we abandon the Great Barrington Declaration as our approach, hospitals which

[278] Yong, E. (2022, February 2). *The Omicron Surge Is Receding. The Hospital Crisis Is Not.* The Atlantic. Retrieved April 8, 2022, from https://www.theatlantic.com/health/archive/2022/02/omicron-surge-hospital-chicago/621455/

are members of the American Association of Medical Colleges will be unable to return to providing full pre-pandemic services.

As stated by former assistant Secretary to OSHA, Jordan Barab:

> *"The only workers who are now required by law to be vaccinated are overworked, underpaid, burned out health care workers and even vaccinations aren't stopping them from getting sick. Even though the vaccine is still proving to be amazingly effective in preventing severe disease and death, it's not preventing a huge percentage of health care workers from getting sick, further straining their health, their sanity as well as the entire health care system. And just to put a cherry on top, in order to save hospitals (and other businesses) from sinking beneath the Omicron wave, CDC allows shorter isolation times for sick workers, likely allowing infectious workers back into health care facilities and other workplaces.*
> *Every other worker — in meatpacking plants, warehouses, grocery stores, restaurants and health care facilities that don't receive Medicare or Medicaid funding — are left completely without enforceable protections — except those weak protections provided by OSHA's general duty clause. ... Is this any way to run a worker protection system?"*[279]

With epidemic covid, the failure to protect all workers, and full implementation of the Great Barrington Declaration, we will try to see a new normal that looks like the old normal. The changes that can be expected will make this old normal impossible. Mass disability from long covid causing havoc to the economy due to an insufficient labor force.[280] Superspreading events, such as the Gridiron Club dinner becoming commonplace. Many will say, as Leana Wen tweeted, not only that "This is our new normal,"[281] but that this should continue and individual risk should matter, ignoring that this is the antithesis of public health. What happened in the United Kingdom with staff unable to work because of sickness causing flights to be canceled[282] can be expected to become commonplace in the United States with many workplaces seeing closures.

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[279] Barab, J. (2022, January 13). *Supreme Court Blocks OSHA Standard, Leaves Workers Without COVID-19 Protection*. Confined Space. Retrieved April 8, 2022, from https://jordanbarab.com/confinedspace/2022/01/13/supremes-put-workers-at-risk/

[280] Picchi, A. (2022, February 1). *A cause of America's labor shortage: Millions with long COVID*. CBS News. Retrieved April 8, 2022, from https://www.cbsnews.com/news/long-covid-labor-market-missing-workers/

[281] Wen, L. (2022, April 8). Retrieved April 8, 2022, from https://twitter.com/DrLeanaWen/status/1512167872264560654

[282] *All the flights cancelled today from UK airports*. (2022, April 8). The Independent. Retrieved April 8, 2022, from https://www.independent.co.uk/travel/news-and-advice/cancelled-flights-updates-gatwick-heathrow-b2053450.html

But even if that does not happen, productivity will drop precipitously because sick workers are significantly less productive. Learning among kids will decrease, and the 200,000 kids who lost a parent because of covid will be a major statistic. Furthermore, this will not stop the crushing downward spiral [283] from healthcare workers leaving.

The decrease in life expectancy from 2020 to 2021 of 0.4 years, which combined with the 1.9 year drop from 2019 to 2020, means a 2.3 year decrease since the pandemic started,[284] which has decreased to 76.6 years, and that is five years lower than the average of peer nations. And because the capacity of emergency departments can be expected to be tremendously diminished, the requirement under the Emergent Medical Conditions And Labor Act to stabilize a patient can be expected to become largely illusionary.[285] That may even cause hospitals to be subjected to significant litigation pursuant to section 1867a(d)(2)(A) due to the damage caused by failure to stabilize patients, for millions of dollars in tort damages for medical malpractice, endangering the economic viability of emergency medicine.

In order to stop this from happening, action must be taken immediately to reverse the implementation of the Great Barrington Declaration and start focusing on reducing transmission of the virus as an urgent public health need by protecting all workers against the airborne transmission of covid. Otherwise, this could be the public health failure of a generation.

Sincerely,

/s/ Theo Allen

Theo Allen

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[283] Yong, E. (2021, November 16). *Why Health-Care Workers Are Quitting in Droves*. The Atlantic. Retrieved April 8, 2022, from https://www.theatlantic.com/health/archive/2021/11/the-mass-exodus-of-americas-health-care-workers/620713/

[284] McPhillips, D. (2022, April 8). *US life expectancy continues historic decline with another drop in 2021, study finds*. CNN. Retrieved April 8, 2022, from https://www.cnn.com/2022/04/07/health/us-life-expectancy-drops-again-2021/index.html

[285] Technically, the act only